Community level perceptions and experiences of reproductive health services among Syrian refugee women in Zaatari Camp, Jordan

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Award date:
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Doctor of Health (DHEALTH)

Community level perceptions and experiences of reproductive health services among Syrian refugee women in Zaatari Camp, Jordan

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Abstract

Background
In humanitarian crises, the reproductive health needs of women do not disappear. Women living in refugee camps, in addition to other complications and hardships, are also prone to other challenges related to their reproductive health life. In Zaatari camp, Jordan, reproductive health care is considered to be one of the most established public service programmes, yet the level of family planning service uptake is relatively low. Few studies have been conducted to gain a deep understanding of the factors influencing women's decisions in this area. Hence, this thesis aimed to generate an understanding of the community- level perceptions and experiences of reproductive health services among Syrian women aged 18-49 years, a component of which is the decision-making process.

Methods
A qualitative study design was used, and data were collected via in-depth interviews and focus group discussions (FGDs) between February and May 2019. Ten in-depth interviews with health professionals and social worker who have experience in reproductive health in Zaatari camp and five FGDs were conducted. Six Syrian refugee women participated in each FGD in the following age groups (years); 18-24, 25-30, 31-37, 38-44 and 45-49. A thematic analysis approach was used to analyse the findings and synthesise codes into themes. The overarching theory used in this study was Dahlgren and Whitehead's 'rainbow model', and two other theories, Lukes's framework, and 'negotiated order' theory, were used to discuss the themes.

Results
It was found that most women were not in a position to make free choices for a multitude of reasons. These include a lack of power and agency among women in the camp to negotiate with family members to decide their own reproductive health life, barriers related to social and community norms that encourage norms, and tradition and culture that expect women to have many children at a young age in order to preserve tradition, maintain the status quo of the tribe and fulfil other social and economic needs. There are also challenges related to the structures of power within the family, particularly the mothers-in law who advocate against the use of such services, and finally interventions that are culturally insensitive and do not correspond to women's needs and their daily routine life.

Conclusions
The key conclusion this thesis was that for women to be empowered to make free and informed choices about their reproductive health, there is a need to train service providers to design a culturally sensitive intervention that corresponds to women's needs and complements their daily life routine, and enables women to be empowered to negotiate their needs with their spouses and mothers-in-law. Moreover, facilitating an enabling environment and opportunities for women to help them start negotiating and making their own decisions regarding their reproductive health with community support for her decision is key.

Keywords

Displacement, camp, refugee, reproductive health and family planning

Chapter 1: Introduction

The purpose of this thesis is to understand and explore the factors which affect the uptake of family planning services among Syrian refugees in Zaatari camp, Jordan.

All women and men should have the right to determine the number of children they want to have, to choose if and when to become pregnant and to space and/or limit pregnancies by using traditional and modern contraceptive methods and/or acquired treatment of infertility (WHO, 2018). These rights arguably include the right to receive services such as comprehensive sex education, and access to all tools that may help them enjoy their right of reproductive health (UNFPA, 2019).

1.1: Background

1.1.1: The use of reproductive health services worldwide and in crisis situations

Rights-based family planning is among the most significant public health initiatives of the last 50 years, having a direct impact on women's health and well-being as well as saving the lives of millions of women and children (UNFPA, 2012). Being able to access family planning can have a profound impact by preventing pregnancy-related health risks, unintended pregnancies and unsafe abortions, and accessing family planning reinforces the right of people to take control of their future (UNFPA, 2012). The U.S. Agency for International Development (USAID) estimated that between 2012 and 2020, these services were able to avert 450,000 maternal deaths in 22 priority countries (Starbird, Norton and Marcus, 2016). The positive impact of family planning was further demonstrated in a study of 172 countries which reported that access to these services prevented 272,000 maternal deaths in 2008 alone. This amounted to a 44% reduction in maternal deaths which would have occurred without the use of contraceptives (Ahmed, Li, Liu and AO, 2012).

The WHO has reported that the utilisation of family planning methods by women has increased in the last few decades in many regions of the world. Globally, the prevalence of modern contraceptive use by women of reproductive age rose from 55% in 2000 to 57% in 2019 (WHO, 2018). In 2017, the United Nations projected that the number of women of reproductive age who use family planning worldwide would increase from 778 million in that year to 793 million in 2030. On a regional level, the prevalence of utilisation is predicted to rise from 23% to 32% in Central Africa and from 43% to 56% in Eastern Africa over the same timeframe (UN, 2017). However, in spite of these anticipated increases, a substantial unmet need for family planning services is evident in that 222 million women were unable to access services in 2012, (Sedgh and Hussain, 2014) and in 2012 around 85 million pregnancies (40% of all pregnancies globally) were unintended (Sedgh, Singh, and Hussain, 2012).

Globally, the number of humanitarian crises is on the rise, as well as the proportion of displaced people in the world's poorest countries. According to Asgary and Price (2018), over 86% of all refugees are living in developing countries which presents an even greater challenge to assuring their health and prosperity. As well as the universal need for access to

healthcare, reproductive health support is essential for women's health throughout their lives and is even more pertinent in emergency situations. More than 32 million women and girls of reproductive age worldwide are in dire need of humanitarian assistance; many of whom are currently living in crisis zones or fragile humanitarian situations having been forced to move as a result of natural or man-made emergencies. The United Nations High Commission on Refugees (UNHCR) stated in 2018 that a quarter of the 70.8 million forcibly displaced people, 41.3 million internally displaced people and 25.9 million refugees are women and girls of reproductive age (UNHCR, 2018 a).

In emergencies, the provision of services is often designed as a temporary intervention despite the fact that the consequences of a crisis are generally long lasting (Merson, Black and Mills, 2012). Based on the Inter-Agency Working Group on Reproductive Health in Crisis (IAWG) (2017), family planning services should be integrated throughout the humanitarian intervention phases starting from preparedness to response and recovery. In Yemen, for example, more than 10.3 million people are in an acute state of need for humanitarian aid due to the continued armed conflict. Through the provision of family planning services as part of the emergency health response in Hodeida and Lahj governorates, 37,347 first time users accessed family planning services between 2013 and 2017, and 60 health workers have been trained on family planning counselling. This multi-faceted approach meets both the immediate needs of women and provides long-term health worker capacity (IAWG, 2017). In 'CARE International', adolescents in the camp in north Kivu were provided with much needed family planning services through a combined programme of outreach activities from health facilities based outside of the camp, generating demand and providing services in satellite clinics to assure privacy and maintain follow up. The programme was designed in collaboration with local peer leaders who helped in developing, implementing and monitoring the activities, and the early investment is improving the long-term uptake of family planning (IAWG, 2017).

The importance of prevention, preparedness and resilience during a crisis has been recognised by international agencies at global level. From this, guidance and policies have been developed to equip communities with the knowledge to better mitigate crises, meet the needs of their people and assure the rights of women caught up in crises, quickening their recovery from the consequences through offering assets, livelihoods, and educational opportunities (Barot, 2017). Since the 1994 International Conference on Population and Development, an improvement in the provision of family planning services to refugees in conflict and humanitarian settings has been observed. However, more work is needed to address contextual barriers on the ground, such as acceptability and uptake, inadequate health care systems, a lack of infrastructure, ideology and socio-culture influences, insufficient data, and resource constraints (Asgary et al., 2019).

At the onset of a crisis, international agencies provide a wide range of health services to refugees and internally displaced people focusing on basic life-saving services including shelter, food and nutrition, water and sanitation and basic health care. Family planning and reproductive health were not included in the standard package of the international agencies until 1994 when the International Conference on Population and Development expanded the definition of maternal and child health services to include access to and the choice of family

planning methods. The Inter-Agency Working Group on Reproductive Health in Crises later developed the Minimum Initial Service Package (MISP) which guides governments in how to better respond to humanitarian crises and support people in conflict and emergency settings by addressing their essential needs. These include focusing on the provision of contraceptives, the reduction of HIV and sexually transmitted infections, the prevention of maternal and neonatal mortality and morbidity, and finally, the prevention and management of gender-based violence (Barot, 2017). However, despite family planning being a component of the MISP and in emergency response guidance, other services, including for other aspects of reproductive health, have been prioritised instead. At the onset of the crisis, family planning provision was reported to be weaker than now (IRC, 2015, Akik C et al. 2020)

1.2.1: Family planning in the midst of the Syrian crisis

1.2.1.1: The Syrian conflict

The Syrian conflict is the worst humanitarian crisis since World War II and the fastest growing refugee crisis globally (West et el. 2017). At the end of 2018, around 11.7 million Syrian people were in need of humanitarian aid; of these, 6.2 million people have been displaced internally (UNOCHA, 2020), and more than 5.6 million people have sought refuge and safety in neighbouring countries since the crisis began in 2011 (UNHCR, 2018 a b). The impact of the crisis goes far beyond Syria's borders, as shown in figure 1, directly affecting Syria's five neighbouring countries: Turkey, Lebanon, Iraq, Jordan and Egypt (UNHCR, 2019). According to the United Nations (2018), Turkey was host to the largest number of refugees in the world in 2018, while Lebanon and Jordan hosted the largest number of refugees per capita of any country. In the region, around 70% of the Syrian refugee people in need are women or children, the majority of whom live in within the community outside the camp (93%). More than a million babies have been born to refugees outside of Syria (3RP, 2018).

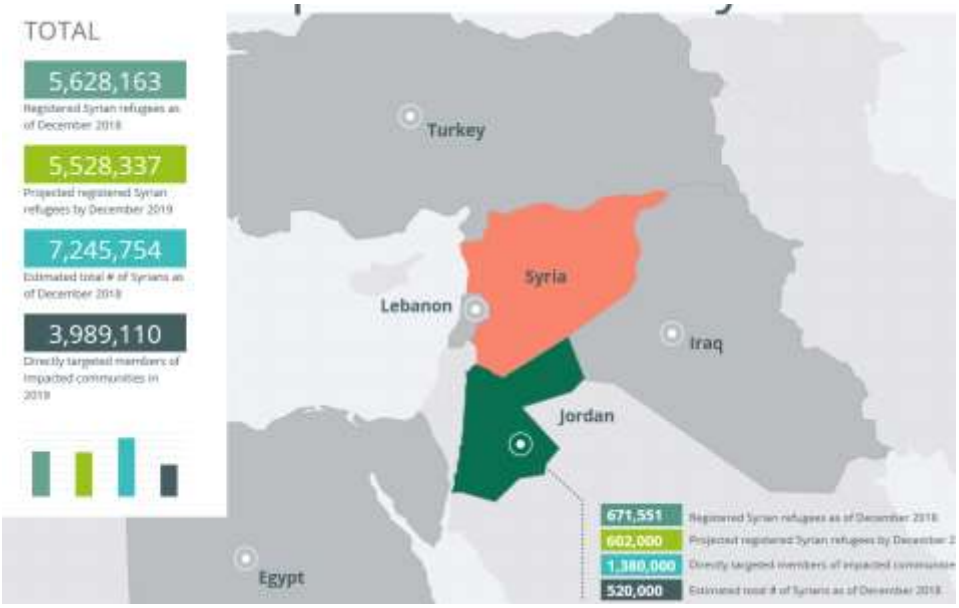

Figure 1: The Syrian refugee crisis in numbers (Regional Refugee and Resilience Plan, 2018)

More than eight years have passed since the crisis began. The complex and protracted political situation has left Syria without security, with damaged infrastructure, a weak and geographically limited system of governance, and people living in fear from the risk of

violence (UNOCHA, 2016). In the countries neighbouring Syria, the sudden and continued demand for services from Syrian refugees in all sectors has placed national systems under chronic pressure and threatens their ability to respond and survive (UNHCR, 2016). Traditionally, the international community addresses the immediate needs of refugees, focusing on interventions for personal development and capacity strengthening activities, through implementing programming, strategies and funding mechanisms (JRP, 2018). However, the long duration of the Syrian crisis has greatly challenged the international response and the standard mechanisms of coordination and provision of humanitarian and developmental support, exposing gaps in policy, funding efficiency and response capacity (JRP, 2018).

An inadequate provision of support can put vulnerable groups in particular at great risk. In the context of the Syrian crisis, there are more than 4.2 million women of reproductive age, typically defined as being between 15-49 years (UNFPA, 2016) and around 7.35 million children under 18 who need humanitarian support (UNICEF, 2020). The absence of established Syrian communities and social networks in the countries where they have sought refuge, along with the challenges of transferring their traditions, culture, language and systems of living, has caused families psychological stress and physiological discomfort (UNOCHA, 2019).

1.2.1.2: The refugee situation in Jordan

Jordan is a lower middle-income country; however, it hosted the largest number of refugees in the world per capita in 2019 (UNHCR, 2019). It has limited resources, but more than half of its population (9.9 million) are refugees, which also includes a large number of Palestinians (DOS, 2012). These include more than 1.3 million Syrian refugees of whom 664,330 are registered (UNHCR, 2020). Among these registered refugees, 160,000 are women of reproductive age (UNFPA, 2017). As shown in figure 2, 81.4% of the total registered Syrian refugees, most of whom are on the poverty line, live in urban settings, mainly in four governorates: Amman (the capital), Mafraq, Irbid and Zarqa (UNHCR, 2018 b). The remaining 18.6% (123,371) live in three camps: Zaatari, Azraq, and the Emirate-Jordanian camps (UNHCR, 2020).

According to the UNHCR, the crisis has increased the population size of Jordan by 10%, as well as changing the epidemiology of disease and placing pressure on national systems and infrastructure (Balsari, et al., 2015). Findings from the health sector vulnerability assessment indicated the local health centres in governorates with higher concentrations of Syrian refugees serve more people than the national standard, as shown this means that almost 39% of the population may receive inadequate services, and 13% of this vulnerability can be attributed to the Syrian crisis (JRP, 2018).

The balance of population demographics in Jordan is also being affected by the crisis. Around 33,000 newborn Syrian babies have been registered in Jordan since the beginning of the refugee influx to Jordan in 2013 (DoS, 2016), contributing to the projection that half of Jordan's population will be younger than 18 years old by 2020. The proportion of the population aged over 60 years is also projected to rise from 5.2 % in 2011 to 7.6% in 2020. These increases in more dependent younger and elderly age groups could have a negative impact on the development and economic status of the country (JRP, 2018). While the

Jordanian economy has managed to maintain overall growth since the beginning of the crisis, the rate of GDP growth has been declining and the unemployment rate rising. In 2017, the total unemployment rate reached 18.6%, with peaks of 33% among women and 30% among youth (JRP, 2018).

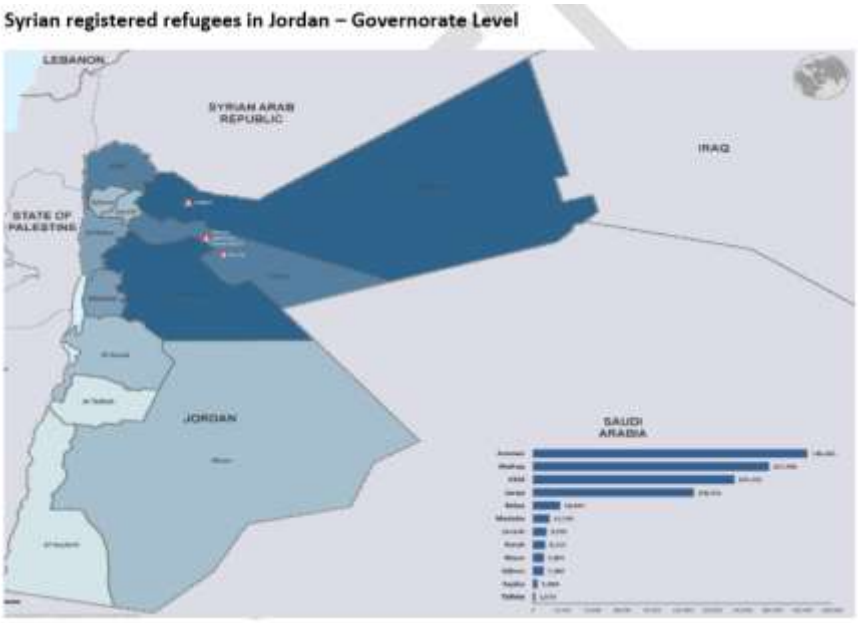

Figure 2: The concentration Syrian refugees in Jordan by governorate (JRP, 2018)

1.2.1.3: Zaatari refugee camp

Of the 123,371 refugees living in camps in Jordan, over 78,000 reside within the five-mile boundary of Zaatari camp, the second largest refugee camp worldwide (UNHCR, 2019); 20,000 are women of reproductive age (JRP, 2015) and 15,710 are aged under five years old (UNHCR, 2018 c). Located in Mafraq Governorate in the North East of Jordan, the camp was opened in 2012 (JRP, 2020) as a temporary solution to accommodate all in-coming refugees with the expectation of them being able to return home to Syria before long. Within the first two years of the crisis three waves of refugees entered the camp, the majority from the city of Daraa in southern Syria (UNHCR, 2018 c).

To begin with, the camp consisted of a network of tents, each housing more than one family sharing one communal toilet and provided communal points for collecting drinking water. These tents were closely packed, and the camp lacked infrastructure, electricity or running water. As the crisis continued with no sign of imminent resolution and deteriorating security conditions in Syria, the international community expanded its regional response plan to provide more services to Syrian refugees. Humanitarian agencies replaced the tents with prefabricated structures, and divided camps into districts equipped with essential services, turning them more into urban settlements (UNHCR, 2018 c). Zaatari camp reached full capacity in 2014, and all new incomers were referred to Azraq camp, in Azraq Governorate (JRP, 2015). Zaatari Camp services include 3,000 shops and business, malls, 29 schools, a maternity hospital, 11 health care centres, 27 community centres, 120 community health volunteers and a judicial court (UNHCR, 2018 c).

Most residents of Zaatari camp are originally from Daraa (79%), others are from rural Damascus (14%), Homs (3%) and Damascus (2%) as detailed in figure 3. The people in Daraa belong to Bedouin tribes, an ancient farming community who live across many small towns; there tends to be strong relationships across and within members of communities and a conservative culture.

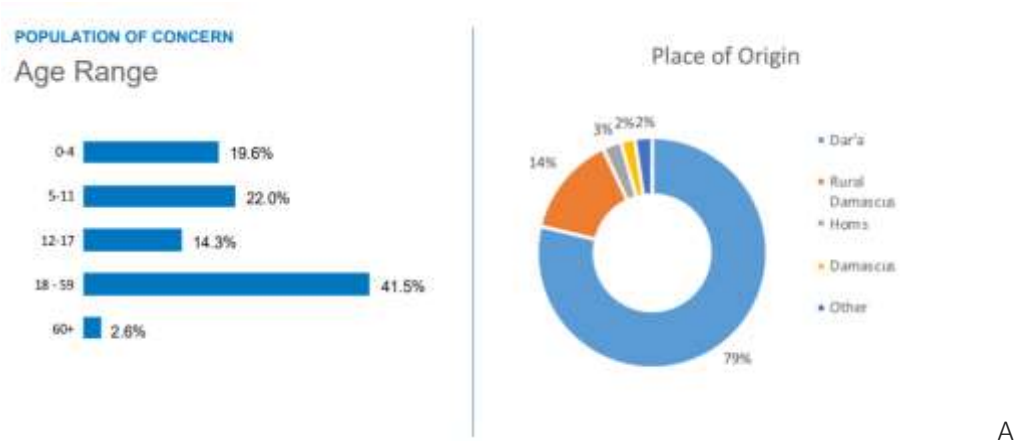

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Figure 3: The population age range and place of origin, in Zaatari camp

The Syrian refugee population who moved to neighbouring countries, including the ones in Zaatari camp, share the same Arabic language as the host communities and these communities are familiar with Syrian cultural characteristics (Kabakian-Khasholian, Mourtada al. et, 2017). In terms of age demographics, over half of Zaatari camp residents are aged under 18 years (55.9%) and 21% of the population are women aged between 18-59 years as seen in figures 3 and 4 (UNHCR, 2019).

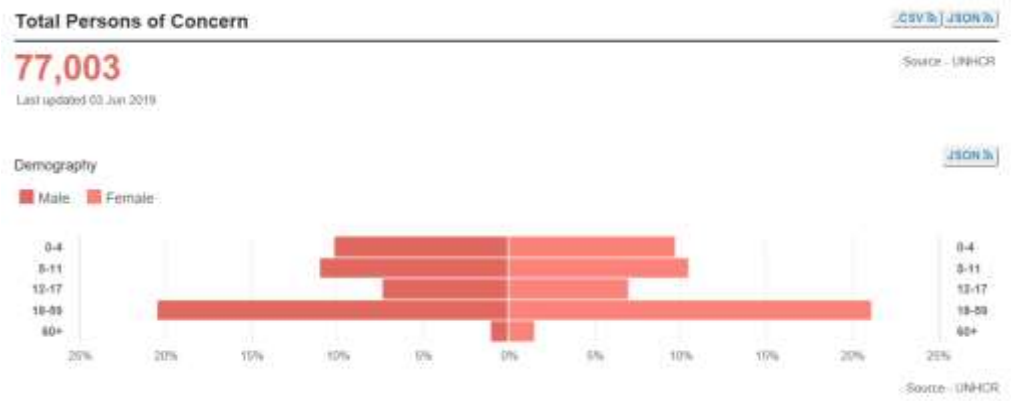

Figure 4: Age and gender demographics in Zaatari camp

1.2.1.4: Health service provision in Syria and Jordan

Prior to the crisis, the Syrian health system had been nationalised with a focus on secondary level care. People in Syria used to have access to health services and medicine free of charge. Information regarding the status of health and service provision at this time was insufficient and access to data was a challenge (Akik, et al. 2020), though research conducted in 2012 stated that access to health care was severely restricted in some areas due to security issues (Kherallah et al., 2012). The health services provided to mother and child at the primary

health care level were disrupted by the conflict and the resulting maternal and child health consequences during the conflict period is unclear. Researchers have concluded that there were inequities in access to health care, a lack of transparency and low quality of care in addition to other detrimental factors related to human resources and a lack of coordination (Kherallah et al., 2012)

The health services provided to Syrian refugees in the five host countries varies. In Jordan, a study by Krause in 2015 confirmed that there was no difference between the quality of services Syrians and Jordanians receive in the country (Krause, 2015). All registered Syrian refugees have the same level of access to the public health care services as the 2.2 million uninsured Jordanian citizens (JRP, 2020). Of the of Syrians who live outside camps, the Jordanian government has identified 36% as vulnerable refugees who were unable to access the services they required due to an inability to pay fees, and therefore some of these people decided to live in refugee camps (JRP, 2020). Moreover, a recent report referred to a mismatch between the interventions designed by humanitarian agencies and pre-crisis programme, and found that common health practices in the community were not taken into consideration (Akik et al., 2020).

1.2.1.5: Health service provision in Zaatari camp

Syrian refugees inside the camp have access to free of charge healthcare, including pre-and post-natal care and family planning services (Al-Fahoum et al., 2015). Women can access these services from four reproductive clinics, one maternity hospital, youth and women only spaces and schools (JRP, 2020). The four reproductive health clinics support an average of 80 births per week and provide 14,000 weekly consultations (UNHCR, 2018). All complex cases are referred to hospitals outside the camp using stand-by ambulances facilitated by the Ministry of Health and funded by the UNCHR (Krause, 2015). Being able to access these services for free and at community level can help prevent barriers to use in terms of geographical accessibility, affordability and acceptability (Haines et al., 2007). Many community-based interventions have taken place since the crisis started, educating Syrian women about the reproductive health services available.

In the four reproductive health clinics supported by UNFPA in Zaatari camp, in the year 2019, no maternal deaths were reported and around 99.7% of births were attended by skilled and trained health workers, as shown in table 1 (UNHCR, 2019). However, no studies or articles were published on the number of women who died in hospitals or at home from maternal or reproductive issues.

Table 1: Coverage of reproductive health services in Zaatari camp (UNHCR, 2019)

Reproductive Health			
Antenatal care	Indicator	Standard	
Coverage of antenatal care (4 or more visits)	86%	≥ 90%	X
Coverage of TT vaccination	83%	≥ 90%	X
Coverage of anaemia screening in pregnancy	89%	≥ 90%	X
Delivery care			
Proportion of deliveries attended by skilled personnel	99.7%	≥ 90%	√
Proportion of deliveries performed by caesarean section	34%	5 - 15%	X
Proportion of low birth weight deliveries (<2500g)	1%	< 15%	√
Maternal mortality			
Number of maternal deaths reported	0		
% of maternal deaths investigated		100%	

General services

There are two centres for women in the camp which aim to build women's resilience and foster empowerment through raising awareness of gender-based violence prevention, leadership and civil engagement initiatives, and through providing protection and other opportunities to improve their livelihoods (UNHCR, 2019). Around 12,000 refugees in the camp have work permits, of whom 1,400 are women, representing 37% of the overall working age population. A further 4,908 refugees have been engaged in incentive-based volunteering opportunities in the camp. Many agencies in the camp offer jobs and training opportunities to women and men. Increasing the number of work permits facilitates refugee movement to outside the camp (UNHCR, 2018).

1.2: Statement of problem

Living up to the commitment from the international community to achieve universal access to reproductive health services by 2030 will require intensified support for family planning, including through the implementation of effective government policies and programmes. Access to health care services and the realisation of reproductive rights for all people will be essential to fulfil the pledge of the 2030 Agenda for Sustainable Development that "no one will be left behind".

Family planning is widely acknowledged as an important step towards achieving Sustainable Development Goals (SDGs) 3.7 and 5.6 which aim to secure universal access to sexual and reproductive health care services and reproductive rights, including family planning. This will in-turn contribute towards improved child survival and a reduction in maternal mortality (Starbird, Norton and Marcus, 2016).

Integrating family planning as a cross-sectoral intervention contributes to advancing progress toward the achievement of the five SDGs themes; People, Planet, Prosperity, Peace, and Partnership, as it facilitates the enhancing of human rights, gender equality and empowerment and shapes economic development. Family planning also affects multi-sectoral determinants that are key to sustainable development such as the education of women and their status in the community (Starbird, Norton and Marcus, 2016).

Stabilising the global population depends on reducing barriers to accessing universal, equitable, and quality family planning services. If this is not achieved, unsustainable population growth will lead to negative consequences for the environment, economy and the development efforts (UNFPA, 2017). For example, Beegle, Christiaensen, Dabalen and Gaddis (2016) stated that due to high population growth, the number of people in extreme poverty increased by 50 million between 1990 and 2012. To control population growth and eradicate poverty and inequality, there is a need to strengthen family planning programmes by eliminating obstacles that prevent couples making informed choices about their reproductive health and enjoying their rights to have their desired number of children.

While Jordan was one of the first countries to commit to the SDGs and has made progress towards achieving them, the Syrian crisis and resulting financial crisis have affected efforts. The sudden influx of refugees who sought safety and security in Jordan has resulted in population growth which has put increased pressure on its limited resources. It has impacted

upon overall development gains in Jordan and represents a serious threat to national resilience. Hence, there is need to address the root issues that hinder the achievement of the goals.

Miller (2010) described the provision of family planning as the most cost-effective intervention to foster human development. Th inter-agency working group on reproductive health in crisis, (2017) confirmed that early investment in this during a humanitarian crisis contributes to a reduction in health care expenditure, and leads to health, economic and educational benefits for both women and communities. A study conducted in Colombia showed that postponing the first birth resulted in substantial socio-economic gains for women, through teenagers (15-19) staying in school for 0.15 more years and being less likely to live with a partner and more likely to work in the formal sector (Miller, 2010).

An increase in family planning use, in the long term, contributes to economic growth through changes in the age structure of populations. In short term, the decrease in the ratio of dependents to income earners lead to increase in percentage of wage earners and to improvements in national savings (Starbird, Norton and Marcus, 2016). Investing one dollar in family planning was estimated to save between US$1.47 and US$4.00 in maternal and new-born health care costs (Singh, Darroch and Ashford, 2014).

From observing the situation among Syrian refugees in Jordan, especially among Syrian refugees in Zaatari camp, the many desperate women stay at home most of the time and young children playing between the prefabricated houses are clear to see, with no sign of hope that a bright future is waiting for them. The printed and broadcast updates on the unpredictability of the security situation in the region and deteriorated economic situation in Syria give rise to the question about the level women and men in the camp comprehend the context they are in, and if they are planning their future or have a clear understanding of the concept of family planning. It has been documented that refugees in the camp live in a state of uncertainty (UNHCR, 2019), though it is known if their decisions regarding their reproductive lives are free and informed, and whether they are aware of their rights and the services provided.

Questions regarding the influence of the community pressure on women's reproductive health rights remain, as well as whether the services themselves are designed based on community-based research and are of sufficient quality to meet the needs of women.

1.3: Aims and research questions

The research question that guided the study is	What are the factors that affect the utilisation of family planning services among Syrian refugee women aged 18-49 years in Zaatari camp, in Jordan?

The aim of this study is to understand women and service providers perspectives of family planning services among Syrian refugee women aged 18-49 years in Zaatari camp, in Jordan.

The findings could help to improve the quality of reproductive health services in Zaatari camp and could also be applicable to improving contraceptive access and uptake in similar settings.

To address this aim, three objectives have been identified:

1. To understand the challenges and motivations that influence the ability to access reproductive health services in Zaatari camp from the women's perspective.
2. To explore the existing family planning care services in Zaatari camp from the perspective of health professionals and social workers.
3. To explore potential solutions to increase the uptake of family planning methods in Zaatari camp from the perspective of refugee women, health professionals and social workers.

The focus of this study is that of women's reproductive rights in a camp setting; it is not aimed at studying the trend of family planning uptake. It is hoped that this wider focus could lead to women having a better understanding of how to make their lives healthier, how to contribute positively to the community, to them being able to identify risks they may face, and to be conscious of consequences and knowledgeable about how to avoid these.

A small number of previous studies have addressed the factors that influence women's decisions in utilising family planning services in Zaatari camp. Most were small in scale but the majority shared the same main finding: that knowledge of and access to family planning is low (Sieverding, et al, 2018). The Health Working Group, a coordination mechanism consisting of all relevant governments, the UN, NGOs and INGOs working in health stressed areas, have identified the need for scaling up family planning services for refugees as a long-standing health challenge and prioritised it accordingly (Health Sector Working Group 2017, 2015).

1.4: Significance of research

This study will generate new knowledge and understanding of the process involved in deciding whether or not to utilise family planning services. It will complement the published literature. Previous research will be built upon by this study through a deeper exploration of the perceptions of women, health professionals and social workers to provide a better understanding of the challenges experienced and barriers faced by women in relation to utilising reproductive health services in Zaatari camp.

Due to the dynamic and unpredictable nature of the Syrian crisis and life in the camp, the motivations and barriers which decide whether women use family planning services or not are unknown. Understanding their perceptions is essential for supporting their reproductive health rights.

The findings of this study will be translated into a list of recommendations for the government and humanitarian agencies working in the camp to enhance reproductive health services and women's wellbeing and to improve the health and development of the Syrian community and society in the camp.

1.5: Thesis structure

Chapter 1: Introduction

The thesis starts with background information about reproductive health services at the global level and in humanitarian settings, then gives an overview of the Syrian crisis in the region and in Jordan, particularly in Zaatari camp, where the study will take place. In this chapter, the researcher explains the rationale behind the study, the research question and objectives of the study.

Chapter 2: Literature review

In the literature review, published literature and studies related to family planning utilisation among Syrian refugees in Jordan and neighboring countries are critically reviewed and analysed, as well as studies of refugee groups in similar contexts. In this chapter, the researcher summarises the health services available inside Zaatari camp and factors that may influence the utilisation of family planning services based on previous research, addressing this from individual, community and institutional aspects. The evidence drawn from the literature aided the researcher in shaping this study and outlining the knowledge gaps to be addressed.

Chapter 3: Methodology

This chapter outlines the methodology implemented in the study, in relation to the main theories used in its design. The researcher explains the data collection techniques used to understand the deep-rooted causes that influence women (aged 18-49) in the camp to utilise family planning services or not, by applying qualitative design, interviews and focus group discussions. The researcher also explains the thematic data analysis applied to analyse the qualitative data and describe the pilot phase as well as the ethical protocols implemented during the study to protect participants.

Chapter 4: Findings

This chapter provides an overview of the results of the study focusing on four themes that were identified using the grouped thematic analysis, namely, tradition and belief, family dynamic, social exclusion, and family planning services. The themes reflect the perceptions of women aged 18-49, social workers and health practitioners toward the utilisation of family planning services.

Chapter 5: Discussion

In this chapter, the researcher discusses the relation between theories and the results of the study, mainly building on the Dahlgren-Whitehead 'rainbow model' (1991), which maps the relationship between the individual, their environment and health, and Steven Luke’s framework (1974, 2005) focusing on the third dimension of power which states that invisible power can influence powerless individuals to act willingly against their own best interest.

Based on the data collected and analysed, it is concluded that for women to be able to take decisions relating to their reproductive health, they need to feel empowered to negotiate and discuss what is best for themselves, their families, and the community they live in. The limitations of the study are also summarised.

Chapter 6: Conclusion

Finally, the researcher shares the conclusion of the discussion and briefly summarises the study and process. This chapter also provides solutions and practical recommendations that could be implemented in Zaatari camp and other similar contexts.

Chapter 2: Literature review

This review aims to provide an overview of literature published on the community level perceptions and experience on planning services in humanitarian contexts with focus on Syrian women living in Zaatari camp, Jordan. This chapter will outline the situation and examine factors lead to the utilisation of services based in published literatures.

Overview of desk review strategy

One of the most important stages of research is the literature review (Samadzadeh, Rigi and Ganjali, 2013). A detailed literature review identifies, collects, and synthesizes relevant published scholarly articles to establish the research questions and assumptions based on accepted tenets and substantive findings in the field. The literature review provides the reader with a foundational understanding of the topic, and a solid background from which to engage the paper; in this case, on the community perceptions and experiences of family planning services in camp settings during the Syrian crisis and other emergency situations.

According to Samadzadeh, Rigi and Ganjali, (2013) it is advisable to use different search engines to avoid systems bias and achieve high quality and focused results. Hence, the researcher used four search engines and an academic database to identify relevant published literature. These included: (http://www.ncbi.nlm.nih.gov/PubMed), Google scholar (http://scholar.google.com), Science Direct (http://www.science direct.com and BATH University library).

The researcher used several key terms taken from Medical Subject Headings (MeSH) and a keyword search strategy to better focus the review and to identify more relevant citations. The researcher entered the following MeSH in the research engines.

Terms: “Syrian women” [MeSH]; “Refugee” [MeSH]; “Jordan” [MeSH]; ”Zaatari camp” [MeSH]; “Za’tari camp” [MeSH]

Effect-related terms or interventions: “family planning” [MeSH]; “reproductive health” [MeSH]; “contraceptive” [MeSH] “Social norms” [MeSH]; “behavior” [MeSH]; “culture” [MeSH]; “community” [MeSH];

Comparison terms: “crisis” [MeSH]; “humanitarian setting” [MeSH]; “camp” [MeSH];

Outcome-related terms: “perception” [Keywords]; “perspective” [Keywords]; “opinion” [Keywords], “experiences” [Keywords].

All relevant articles published in English and Arabic between 2000 and 2020 were retrieved, including quantitative, qualitative, and mixed methods research. The researcher reviewed recently published books, strategies and reports on women’s health in humanitarian contexts, family planning strategies and humanitarian efforts in relation to the Syrian conflict and regional development. In addition to the search engines, the following web platforms were

used to source grey litrerature: United Nations Population Fund (UNFPA.org), UNICEF (unicef.org), The World Health Organization, (WHO.int) and The United Nations High Commissioner for Refugees (unhcr.org).

The researcher developed inclusion and exclusion criteria to assess the published literature. Studies with primary data or secondary data analysis on family planning and how the community perceives it, and which were conducted with Syrian populations living either in Syria or as refugees in neighboring countries (Egypt, Jordan, Lebanon and Turkey) were included. The researcher excluded articles that discussed the technical side of reproductive health services, such as pre-post-natal services, delivery, family planning tools and child health, and which were not include information on Syria or the Syrian population. All selected articles were imported into EndNote reference manager, and duplicates were deleted.

Design: The review aimed to check the community perception and experience and the knowledge, beliefs and opinions of women about the utilisation of family planning care, barriers utilizing the reproductive services in camp setting. Moreover, to examine the perspective of health professionals on how to promote and enhance reproductive health care services in camp settings.

Analysis: More than 160 articles and publications were initially screened and categorised, and of those 90 were considered most relevant based on the subject matter and methodology were included in the analysis. The researcher used Dahlgren-Whitehead 'rainbow model' as a reference when collecting and analysing information from the selected articles on factors influencing health outcomes. Specifically, the interaction between individuals and their surrounding social and physical environments, and how this applies to a woman's ability or willingness to access family planning services will be explored, particularly the impact of socioeconomic and cultural factors. Moreover, the researcher followed geotemporal categories: Syrian pre conflict, Syria in 2011, Syrian refugees in Jordan, Lebanon, Egypt and Turkey and refugees in similar contexts.

Findings and interpretation of data

A large amount of research has been conducted on the accessibility and quality of reproductive health care for Syrian refugees in Jordan and the region. However, very little of this work discussed the uptake of family planning services among Syrian refugees in general and even fewer inside Zaatari camp. Therefore, the researcher examined other available data sources from similar settings to help enrich the literature review.

The search focused on three categories:

- Challenges and motivations from a woman's perspective that influence their decision on whether to access reproductive health services in Zaatari camp (or similar settings)

- Challenges and motivations from a health professionals and social worker's perspective that influence women's decision making in the camp on whether to access reproductive health services

- Provision of quality services and promoting the usage of family planning care in camps setting from health professional's and social workers' perspective

2.1: Family planning during the Syrian crisis

Emergency situations can have a devastating impact on society, particularly for the women and girls who face added risks and health consequences on top of the challenges of losing their livelihoods, assets and opportunities. These circumstances render them vulnerable to the risk of both physical and mental trauma, violence, chronic disease and malnutrition due to the collapse of societal structures, or disintegration of their family and social networks. Additionally, the weakening of health systems and a shortage of quality reproductive health services exposes women to the risks of unwanted pregnancy, unsafe abortion, maternal health issues and even death (WHO, 2018). These dangers are amplified among refugee women, who are more likely to have a higher risk of reproductive health issues than women in host communities, which has negative consequences for their physical, psychological and social health and well-being as well as for their families and wider community (Mengesha et al., 2017).

Women suffer twice over from the Syrian crisis, through experiencing the insecurity, instability, and disruption of normal life as well as enduring the difficulties of being a woman in a society that does not value them as highly as men, being afforded limited rights and fewer opportunities (UNFPA, 2016). As a consequence, Syrian refugee women endure the risk of sexual and reproductive health issues such as frequent urinary tract infections, complications during pregnancy, unwanted pregnancies and a lack of access to antenatal care (Samari, 2014). Moreover, they must live with the threat of gender-based violence and its consequences (Ward and Vann, 2002).

The process of displacement contributes to changing fertility and reproductive health practices among women in the world (McGinn, 2017). Prior to the Syrian crisis, the fertility rate among Syrian women according to World Bank statistics in 2012, which is the latest available data so far, was the sixth highest in the Arab region (World Bank, 2012); it later increased again once Syrian refugees were settled in neighboring countries (Kabakian-Khasholian et al., 2017). According to the UNHCR (2017), the total fertility rate among Syrian refugees in Jordan as shown in figure 5 is 4.7% compared to 2.6% among Jordanians and 1.9% from other nationalities. This rate increases as household wealth decreases. According to the Demographic and Health Survey (DHS) 2017, the fertility by household wealth was 3.9% among the lowest wealth quintile where almost all Syrian refugees came from. The median age at first birth is the lowest among the Syrians aged 30-49 (21.4) compared to 24% among the Jordanians.

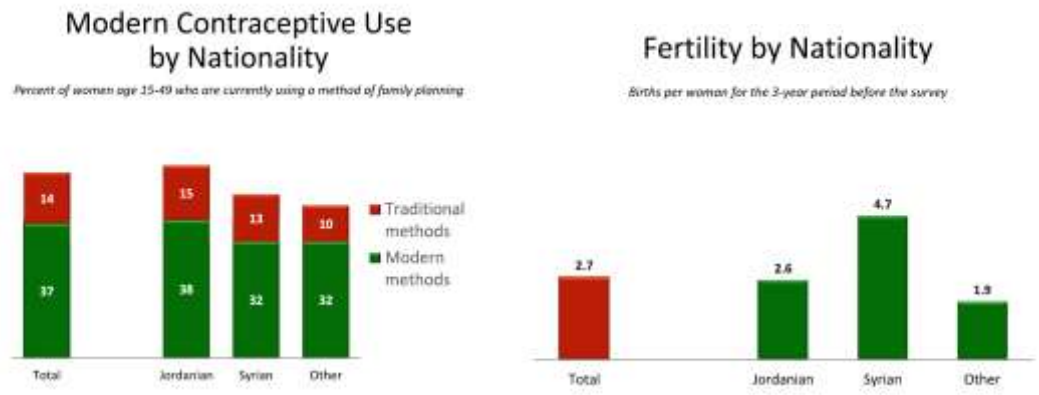

Figure 5: Fertility by nationality and modern contraceptive use by nationality, DHS 2017

The findings of the National Survey in 2006 stated that, before the crisis, 73% of ever-married Syrian women reported using contraceptive methods at least once during their lifetime (SCFA, 2006). However, according to the Central Bureau of Statistics (2011), this percentage declined to 54% in 2009 (59% in urban and 47% in rural areas), and of this total 22% use intra-uterine devices (IUD), 8.9% use pills and 3.5% injectables. The same report explains the various factors behind the decline, such as fear of the side effects (19%), spousal control and disapproval of family planning (13%), not wishing to use the existing methods available (9%) and the belief that conception is the will of their God.

Among currently married Syrian women living in Jordan, 53% use modern contraceptives, a higher figure than pre-crisis contraceptive use by women in rural areas of Syria (47 %). Just under a third of these women use modern contraceptives, 16.3% use IUD and 12.7% use any traditional methods. The total proportion of Syrian women using contraceptives is lower compared to Jordanian women, despite the fact both receive the same quality of services and have access to the same primary health care centres (DHS, 2017).

There is no consensus regarding the level of awareness of family planning services among Syrian women living outside camps in Jordan, this could be due to the time point at which data were collected or related to the methodology used. The Demographic and Health Survey (2017) found that Knowledge of family planning methods provided in primary health care centres is almost universal among Syrian women living outside camps in Jordan (over 98%), and decisions are primarily made jointly by the husband and wife (82%) (DHS, 2017). However, these findings do not align with other studies of Syrian refugees in Jordan which suggest that knowledge of family planning and methods services is low (Sieverding et al., 2018). The level of support offered or sought for family planning is seemingly low with only 8% of the Syrian women reporting having been visited by a field worker to discuss the subject while 10.6% had visited a health facility in the 12 months prior to discuss family planning (DHS, 2017).

When considering women living in Zaatari camp, which DHS data does not cover, around 90% reported being knowledgeable about family planning services (UNICEF, 2014). However, the latest study conducted by UNICEF in 2015 showed that only 24% of women inside the camp

utilised the freely available reproductive health services, less than half of the rate of utilisation by Syrian and Jordanian women living outside the camp (Krause, 2015). There are no more recently published quantitative studies conducted in the camp with the exception of some progress reports by UNFPA which show that utilisation of family planning services increased from 2014 to 2018 (UNFPA, 2014, 2016 and 2018). It is not clear if utilisation of family planning services among women inside the camp is based on an informed decision or whether there are barriers that hinder women accessing services. The deep-rooted factors that drive and hinder women accessing reproductive health services in the camp are unknown.

2.2: Factors driving the utilisation of family planning services in humanitarian context

From reviewing published literature, it is evident that fertility practices change with migration (Bagavos, 2019). Women in crisis are vulnerable, displacement affects their self-esteem, self-efficacy and take informed decisions (Kabakian-Khasholian et al., 2017). During displacement their personal goals or life plan changes in response to the situation they are in (UNHCR, 2008). Many personal, interpersonal, social and structural factors affect refugee women's decisions and abilities for birth spacing in camp settings (Ackerson and Zielinski, 2017). Some of them internalise other external factors related to the context they are living in.

Many studies refer to the complexity that women face and interact with in their journey during displacement. Others stated factors which influence Syrian women's knowledge, attitudes and beliefs in the camp context, which eventually either enable or constrain their actions. The following sections explore the current understanding of these influences in more detail. The studies were reviewed and analysed following Dahlgren and Whitehead's 'rainbow model', which considers range of factors that influence the health and well-being of individuals and populations across all age groups, both within and outside of the individual's control. This model captures also the interplays between factors in different layers that influence an individual's potential for health. Some layers contain non-modifiable factors such as age, sex and genetics, while other layers refer to modifiable factors related to lifestyle, the physical and social environment and wider socio-economic, cultural and environmental conditions.

The Dahlgren and Whitehead model provided a framework for analysing the relevant literature and mapping the factors which emerged from studies on the community and women's experiences and perceptions. This aided narrowing the focus of the research to the modifiable factors, and exploring the relevant influence of these on Syrian women's reproductive health outcomes, as well as how the camp context affected the interactions between these determinants.

2.3: Social and community networks

2.3.1: Cultural practices

A study conducted among Syrian refugees living in urban settings in Jordan highlighted the relationship between family planning service uptake and the influence of tradition, norms and

culture (UNICEF, 2014). According to Dieudonné et al., (2016) social norms, cultural attitudes and quality of services has a strong impact on the uptake of family planning services. Women's behaviors are not only shaped by enhancing knowledge and changing rational, emotional or cognitive biases and impacted attitudes but are also affected by social expectations and community influences (Petit and Zalk, 2019).

Women living in conservative settings, where traditional values form the framework of society, care to a greater extent about how they are perceived and treated by their community and therefore are more likely to follow what is thought of as acceptable, normal or appropriate by the majority of the community, leading to these community behaviours becoming rules that guide women's life decisions (Petit and Zalk, 2019). This can occur to such an extent that some women may act against their own perceived self-interest or personal beliefs in order to comply with what others in the community expect of them, thereby gaining social approval or avoiding social sanctions (Harbert, 2015). Petit and Zalk (2019) argued that with displacement and in humanitarian context, women become more conservative and roles become more restricted.

In many settings, the norms and culture limit women's purposes in life to childcare and domestic care (Herbert, 2015), as is stated in many reports on the Syrian crisis by UNHCR (2014, 2017 and 2018). It was also observed in other conservative societies in the Middle East that young women are raised to assume the role of mother and have many children as soon as possible (DeJong et al., 2017). Furthermore, Daniel et al. (2008) stated that in Asia and sub-Saharan Africa, the societal and family expectations dictate that women should become pregnant and give birth soon after marriage. Expectations and perceptions, as stated by Herbert (2015), are usually rooted deeply in beliefs and influenced by social status, age, gender, religion, emphasis on following tradition, education and employment status, and so on.

Marrying under the age of 18, also known as child marriage, is highly accepted in the Syrian community and the prevalence is high in all countries affected by the Syrian crisis (UNFPA, 2016, DeJong et al., 2017) This practice is promoted as a good example to follow as it allows women to bear children as early as possible and to do so continuously (Munshi and Myaux, 2006). Syrian refugees in Turkey have been found to be under pressure from their community to have many children at an early age (Karakaya et al., 2017; Dikmen, Cankaya and Yilmaz, 2018). Marrying young is seen by Syrian refugees in other countries such as Jordan and Lebanon as a means to relieve financial pressure, provide security and have a greater number of children (UNHCR, 2017 b). Child marriage and bearing children at a young age was also observed in Bangladesh by Munshi and Myaux, (2006) who stated that traditional norms regulated fertility and promoted child marriage as a good example of how to achieve immediate and continuous childbearing.

Practices and preferences such as child marriage and the size of the family respectively were brought by Syrians into the countries which they fled to (El Arab and Sagbakken, 2019). According to the Syrian Commission for Family Affairs (2006), Syrian families desired an average of 4.9 children, and this practice remained in place as Syrians fled to and settled in other countries. For example, in Lebanon, Syrian refugee women were reported to believe that to be accepted by the community, they should have four to six children (Kabakian-

Khasholian et al., 2017). Similar findings were also identified in a study in rural Pakistan with a similar context, where migrant couples do not practice family planning in order to avoid social stigma and gain respect due to having a higher number of children (Mustafa, Azmat and Munroe, 2015). In order to try and create a sense of normality to help them feel safe and secure, the people in Zaatari camp try to replicate the lives and practices they had back in Syria (Al-Fahoum, 2015).

Many studies show that cultural practices and norms can influence family size, fertility rates, timing of marriage, gender preference, and contraception use (Schuler, Rottach and Mukiri, 2011; Campbell, Prata, and Potts, 2013, DeJong et al., 2017).

2.3.2: Gender preferences

The preference for having a large and predominantly male family is part of Syrian tribal tradition and is deeply rooted in culture, and as stated in a UNHCR report, women will keep giving birth until they have a male child (UNHCR, 2015). This desire for male children has been documented among Syrian refugees (UNHCR, 2015 and Karakaya et al., 2017) though it is by no means unique to their culture and has been found in many countries such as Nepal (Herbert, 2015) and Palestine (Nemmi, DuLou and Greive, 2015). Gender preferences can be said to influence fertility and family planning decisions among Syrians living in Zaatari camp, as male children are seen to be essential for enhancing the status of a family. This premise aligns with a study which reported that the ways in which masculinity and inequitable gender norms influence family planning practices are not limited to gender preference for children but goes beyond this to desired family size. Reshaping traditional norms of masculinity among men may delay the onset of fatherhood, reduce the desire to father children from different women and affect what male children learn about social expectations and gender roles (Walcott et al., 2015).

The perceived economic utility of producing large numbers of predominantly male offspring is rooted in the Syrian cultural and norms that were carried over after displacement (UNHCR, 2017 a). Syrian families consider male children as representing the continuation of the family name, and as the provider of support to female siblings and parents in their old age, hence the necessity felt to have male children in the family (Kabakian-Khasholian et al., 2017). In Turkey, Syrian refugees wish to have male children in order to maintain their sense of origin and status in the community, and to help them in farming and other manual work (Karakaya et al., 2017).

2.3.3: Desire for large families

The demand for a big family among Syrians as stated by Kabakian-Khasholian et al. (2017) comes from either the husbands or family elders, as well as it being an expectation of the community. Literature from rural low-resource and humanitarian settings further substantiates that larger family sizes are perceived by communities or ethnic groups as advantageous. Such an advantage grants them additional security, safety, and prosperity and is considered as a financial and a social service investment in the parents' livelihood and assistance in undertaking family duties in a subsistence structure (Asgary and Price 2019). In general, having many children in itself is considered a social and financial investment for the family (Schuler, Rottach and Mukiri, 2011; Campbell, Prata, and Potts, 2013).

In a crisis context and due to displacement, parents-in-law tend to put extra pressure on their sons to have many children in quick succession to compensate for the number of children who died as a result of the crisis. This phenomenon has been reported among Syrian refugees in Lebanon and Iraq (Balinska et al., 2019). In conflict situations, where health literacy is low, health care is inadequate, and child mortality is high, many perceive family planning as a counterproductive action that prevents women having a large family (Asgary and Price, 2019).

2.3.4: Fear of consequences

Crossman (2019) highlights that women are subjected to negative consequences as a result of violating or not following the shared norm, ranging from feeling shame and depression experienced as a result of social exclusion to suffering a sanction imposed by an authorised body on an individual such as public humiliation, arrest or punishment. Women who are voluntarily childless or have only girls are regarded as failures, and may be verbally abused (Nefaah Tabong and Adongo, 2013). As a consequence of sanctions, women prefer to exclude themselves from gatherings to avoid feelings of personal inadequacy (Nefaah Tabong and Adongo, 2013).

The negative consequences suffered by women due to these sanctions can sometimes extend to emotional and physical abuse. This theme of punishment is also noted in studies such as Leke et al. (2004) and Dyer (2007) which state that infertility is considered as a major cause for divorce, fear of abandonment and polygamy in Syrian culture. Polygamy, the rate of which according to the Central Bureau of Statistic (2002) was 5.1% in Syria, has become a more significant threat to women after displacement, as women are more exposed to men due to frequent outings for grocery shopping or to access services, which increases women's interaction with men (UNHCR, 2018). Moreover, in the camp there are more interactions between men and women, which was not the traditional norm back in Syria. Women must often, therefore, choose between having children to satisfy their husbands or accepting a polygamous marriage in order to avoid being isolated in the community (Kabakian-Khasholian et al., 2017).

Two studies among Syrian refugees in Lebanon, and Afghani refugees in Iran, revealed that many women do not openly use contraceptives, in order to become closer to their husbands, being in constant fear that their husbands may take a second wife (Kabakian-Khasholian et al. 2017; Tober, Taghdisi and Jalati, 2006), and this is also accepted in other similar contexts such as in Iran. Marriage to multiple wives, divorce and abandonment are very common phenomena in Zaatari camp and women feel that becoming pregnant more often will protect them and lower their risk of physical abuse (UNWomen, 2016; UNHCR, 2017 a).

As a result, some female Syrian refugees in Lebanon utilise contraceptives without their husband's knowledge or against their wishes (Nalwadda et al., 2010; Kabakian-Khasholian et al., 2017). This is consistent with evidence from Tanzania and Uganda which states that women used contraception in secret or against the wishes of their husband despite that risk that it may lead to violence or divorce (Schuler et al., 2011; Nalwadda et al., 2010).

2.3.5: Religious practices

In many crises, morality and religion are major influences on the decision whether to use family planning (Asgary and Price, 2019). A study conducted by Ussher, Perz and Metusela (2017) in Australia and Canada revealed that some Muslim refugee women were strictly forbidden to use contraception as it was considered to be 'killing a child'. Moreover, religious beliefs among the Syrian community in the camp dictate that women should keep producing children until they are no longer fertile, substantiated by many religious narratives and Quran verses that highlight the importance of childbearing (Kiani, 2007), with family planning said to be a sin according to Islamic beliefs as reported in a study by Dikmen, Cankaya and Yilmaz (2018). Religion can, therefore, be considered as a factor for the high fertility rate. Another study conducted in Iran also found that religion influences the number of children in a family and promotes increased fertility. Taken together this explains the higher fertility rates among individuals and families with stronger religious beliefs, similar to the situation seen among Syrian refugee women in Lebanon who confirmed that their desire for a certain family size and 'Rezqa' are determined by God (Kabakian-Khasholian, 2017).

2.3.6: Conservative influences

In a conservative community, women are affected to a greater extent by the knowledge, beliefs, emotions, perceived risks, social norms, self-efficacy and trained and skilled people around them (Ackerson and Zielinski, 2017). In the camp context, most family planning practices are inherited from elders, and most women first find out about family planning after marriage or after the first delivery through discussions in non-formal educational sessions. This kind of influence from elders in the camp so-called reference group results in women following this one and only source of information in their surrounding environment, particularly as they perceive the elders as caring about them (Herbert, 2015). Women are therefore influenced by their immediate surroundings, family, friends and the social network (West, at al., 2017), and their behaviors do not necessarily reflect their personal beliefs but the common norms in the society (Ackerson and Zielinski, 2017).

A study by Herbert (2015), presents further reasons for the lack of involvement of women in family decision making in conservative cultures such as the lack of experience and confidence, the cultural sensitivity of the topic, their partner being opposed, and misinformation. This is consistent with the findings of Nalwadda et al., (2010). Looking at the explanatory factors, we can conclude that a lack of spousal communication is a key to the underutilisation of family planning services. This is further reiterated by (Char, Saavala and Kulmala, 2010) that communication helps in boosting positive contraceptive use, but that in the Syrian community, women and couples do not discuss family planning and do not plan for their children's future.

2.4: Individual lifestyle factors

2.4.1: Family influence

Schuler, Rottach and Mukiri (2011) concluded in their research about the role of gender norms in family planning decision-making that men's dominance is a barrier to the use of

modern contraceptives. Gender related factors sometimes block women from realising and practicing their rights and hinder them from accessing family planning freely. Hence, the husband's approval of family planning is considered as a crucial factor for women's ability to use family planning services (Herbert, 2015).

Many Syrian women accept the dominant role of men, due to a variety of reasons such as feelings of shyness and fear, or the idea that men know better (Kabakian-Khasholian et al., 2017). Many Syrian women refugees in Turkey accept the dominant role of men in making decisions about family planning as they perceive that men are also influenced by social norms, culture and religious expectations, and that their responsibility is to fulfil their husband's desires of having a large family and conceiving male children (Kabakian-Khasholian et al., 2017). This is backed up by the findings of a study in Afghanistan which stated that men are constrained by tradition, and that women have to accept their situation and support them in following the norms (K4Health, 2007). This is similar to the situation in South Sudan where men decide when and how many children to have (UNFPA, 2014) and is further reflected by Orach et al. (2015) in northern Uganda where it was found that men make the family planning decisions during the post-conflict time.

The opposition towards use of family planning services by men was also observed in studies carried out in Tanzania and Uganda (Schuler et al., 2011; Cleeve et. al., 2017). Research conducted in the Indian state of Uttar Pradesh found that being in a conservative setting put an extra level of restriction on women's mobility which negatively impacted the use of contraceptives (Mishra et al., 2014). Mustafa, Azmat and Munroe (2015) found that female mobility in rural areas of Pakistan is restricted and that they are not allowed to go to a medical centre without the permission of their husband and mother-in-law, and it is assumed that they should be accompanied by other women, as a woman who walks alone is considered to bring dishonor to the family. However, some men believe that the family is women's business, and they are not interested in seeking information on family planning from reliable sources (Schuler et al., 2011).

Mishra et al. (2014) emphasised the significant role of men, mothers-in-law, community elders or peers in making decisions related to family planning. Such decisions, in many relationships, may or may not involve the women themselves. This is in alignment with the findings of a study by Herbert (2015), that the social norms grant husband and in-laws the decision-making authority and control over women as their opinions are perceived to have more value. Tesfaw (2012) and Mustafa, Azmat and Munroe (2015) confirm what Herbert (2015) concluded in his study that in some cases, parents and in-laws get involved in their children's family planning decisions. For instance, in rural areas in Pakistan, the mother-in-law has the power and the control over family planning decision making as it is considered an integral part of the culture (Mustafa et al., 2015).

Curry, Rattan and Giri (2015) stressed the importance of addressing women and men equally in awareness raising interventions, as in many cases men object to the utilisation of contraception thinking that it affects fertility. This was also reflected in research by Asgary, Joan and Price (2019) who highlighted the importance, for both women and men, of being

informed about family planning and contraceptive options. Furthermore, Apanga and Adam (2015) stressed the importance of considering males in all social mobilisation and counselling interventions and also using religious and spiritual leaders to educate refugee communities as they may be more effective in reconciling societal ethics, faith and morality, with family planning services (Asgary and Price, 2019). A UNFPA report (2016) found that a session for men on reproductive health was conducted in the camp but did not include information on the effectiveness or impact.

2.4.2: Knowledge and awareness

Looking to the standard for successful health promotion approaches, we can learn that individuals, families, and communities must have knowledge of the services available, then understand the benefits, believe that these services are safe and effective, and feel that using contraception is socially acceptable (Engender Health, 2011). Accordingly, raising awareness of reproductive health services is one of the main recommendations of MISP and other global humanitarian crisis response guidelines (UNFPA, 2018, UNHCR, 2011 and UN, 2010). However, the level of knowledge in camp settings varies; for example, the level of knowledge about modern contraceptives is 80.7% among Cameroon refugees (Halle-Ekane et al., 2016) while it ranges from only 4% to 16.2% among refugee women in eight conflict-affected areas in Sudan, Uganda and the Democratic Republic of Congo (McGinn et al., 2011).

In practice, the association between the level of awareness and contraceptive uptake or level of services provided varies between contexts. Studies show that raising awareness among women of types of contraception methods and addressing the benefits and consequences of family planning on the health of women in humanitarian settings helps women and men to have an informed discussion about family planning (Asgary and Price, 2019; Curry, Rattan and Giri, 2015). For example, a study by Karakaya (2017) confirmed that there is a relationship between the level of education, awareness of family planning and the utilisation of family planning services among Syrian refugees in Turkey, while another study by Saxena et al. (2006) found that a lack of educational empowerment in Pakistan, Egypt, Jordan and Indonesia was associated with a lack of family planning knowledge, non-supportive attitudes and low prevalence of contraceptive use.

This association cannot be generalised, however, since in practice, the relationship between the level of awareness and contraceptive uptake or level of services provided varies between contexts. The level of awareness among Afghani women in Pakistan refugee camps who receive free-of charge health care services is 89%, compared to Afghan women living elsewhere in Pakistan who do not receive supported health care services or do not know much about family planning care (45%) (Raheel, Mehtab and Karim, 2012). In Cameroon, over 80% of refugees are knowledgeable about modern contraceptives and believe that contraceptive use could prevent pregnancy but just 36.4% use family planning methods (Halle-Ekane et al., 2016). This is also the case among the women in six conflict areas in northern Uganda, Sudan and the Democratic Republic of Congo, only 4% of whom use modern methods in four sites and 12% and 16% in the other two sites, yet 30% to 40% of refugee women stated their desire to not have a child within two years, and 12% to 35% did not want additional children at all (McGinn et al., 2011).

Asgary and Price (2019) and West, et al. (2017) concurred that community awareness is essential to improving understanding and leading to increased rates of informed use of contraception, though decisions are mostly influenced by familial and community preferences, needs and beliefs. These conclusions were also reached by Olaitan (2009) who stated that there was no significant association between attitudes towards the uptake of family planning methods and the level of individual awareness of reproductive health services. In the context of Zaatari camp, only 20.4% of Syrian refugee women use family planning methods, despite their high level of knowledge of the benefits of spacing births and the availability of free services (90%) (UNICEF, 2014). The reason for lower than expected utilisation as stated in UNICEF's report was thought to be due to the inconsistency in availability of methods over time (UNICEF, 2014) or was also theorised as being due to cultural sensitivities as sexual education is deemed unacceptable in the community (Krause, 2015, DeJong et al., 2017), poor and inaccurate information about family planning (West, et al., 2017) and was never discussed back in Syria (Kerstein, 2014). The outreach activities on reproductive health services were also reported to be very limited (Krause, 2015) and the need to raise awareness about services and address misconceptions was highlighted by West et al. (2017). These findings translate to knowledge alone not being enough to increase the uptake of family planning services (Apanga and Adam, 2015) given the importance of other social, structural and psychological cognitive factors (Yorkovsky and Zysberg, 2020).

2.4.3: Level of empowerment

Power dynamics influence several aspects of sexual and reproductive health, for example decision-making within families and relations between patients and health providers. The role of power in shaping health status has been theorised in many scientific fields ranging from social psychology to anthropology and political science (Schaaf, et al., 2021). An integral component of power dynamics is the concept of empowerment, as this is intimately related to changes in power, specifically the gain, use, diminishment and loss of it (Hur, 2006). The definition of power and empowerment from health and social perspectives is context specific, varying depending on the perspective, whether an individual or collective level is being examined, and if power and empowerment are seen as a process or an outcome (Rissel, 1994; Rodwell, 1996; Tones and Tilford, 2001; Spencer, 2013).

The process of decision making is further complicated during a humanitarian crisis as women have less control over their health and are even more dependent upon family and community for their health needs and protection (Vlassoff, 2007). Many studies reported that Syrian women do not make the decisions alone (Krause (2015), as many do not have sufficient liberty to make such a choice (Karakaya et al., 2017). In most cases a woman's decision regarding family size is likely to be strongly influenced by both her family and normal practices in the community (UNHCR, 2015; Ackerson and Zielinski, 2017).

Returning to the definition of power, the term 'power' refers to the synonyms of "possibility" for and "ability" of an individual or group to have the capacity, including physical strength, to take an action; be subject to something; or have the reasons to act on something (Cavalieri and Almeida, 2018). Power itself is seen as an entity which can be possessed and utilised the same way as any other resource, and can be presented as a natural talent (e.g., strength and

intelligence) or something acquired (e.g. wealth) which can be utilised to achieve whatever is desired (Cavalieri and Almeida, 2018; Junges et al., 2019).

The utilisation of power is a process in which a person's agency is interlinked with their inherent capacity and social structures to influence the world around them. Therefore, power resides with status or ability to make decisions (Cavalieri and Almeida, 2018). Following this school of thought, if the women are able to identify the issues relevant to them and how these should be addressed and negotiated, they too can start taking steps to be able overcome the constraints on their freedom to choose and gradually take ownership over their health.

The concept of power is a key consideration for understanding the process of empowerment (Sadan, 2004), this being not a static idea but rather the interaction and the interdependence between individuals with differing levels of power (Junges et al., 2019; Bourdieu, 2001; Pinto, 2011). The relationships that exist between human agency and social structure are dynamic and procedural (Hur, 2006). The social structures of family and community which exerted both direct and indirect influence over women, with the interactions between different barriers complicated by the restrictive environment. Empowering women to gain decision-making authority and control over their personal lives is important to build an equitable and sustainable community. Empowerment is important in many contexts beyond the economic sphere, such household power dynamics and relations, rights and responsibilities, as well as participation in the political and social development (ILO, 2017). Studies have shown that the empowerment of women is a driving factor for family planning service utilisation in countries with a low prevalence of contraceptive use (Goldman and Little, 2015; Hardee et al., 2014; Kabeer, 2005; Kabeer, 2001).

For women to be able to get involved in the decision making process they need to be empowered, to believe in themselves, to be self-determined, and able to define their reproductive desires and feel that they are doing something meaningful for themselves based on their own values. Being empowered means having the understanding and ability to choose one's own behaviour, and being confident in making the choice (Seibert, Wang, Courtright, 2011). This is reflected in an analysis, conducted in 32 regions of sub-Saharan Africa by the DHS, involving 474,622 women of reproductive age, which revealed that there is a significant association between the increased utilisation of contraceptives and women's empowerment (Yaya, et al., 2018). The study took into consideration the relevant socioeconomic dimensions in the DHS tool, but does not define the exact meaning of empowerment or cover other contributing factors such as cultural perceptions, social relations and national and local legislation. These are especially key to understanding whether the women are making free and informed choices about their reproductive lives and if their decisions are based on their own wishes and are accepted by society.

It is important to understand that the nature of power in Arabic countries is strongly influenced by culture tradition, religion and the broader dynamics of society (ElSafty, 2003). Arabic countries have a strictly male-dominated culture, where male supremacy is the norm. Women's rights are yet to be fully recognised across the region, and in some cases women are being denied and deprived of their basic human rights, particularly in matters of personal status.

Factors relating to tradition and culture have prevented the fully recognition of Arab women's role in development, gender equality and efforts to eradication discrimination against women. Inequality is evident in access to education, employment opportunities, political rights, and the rights each partner has in marriage. Moreover, in some counties there is clear legal discrimination and laws are not gender sensitive. However, the situation varies widely between countries, from those with extreme traditionalism to those with a reasonably liberal society (ElSafty, 2003).

In a traditionally male-dominated society, women in general are a vulnerable group, this imbalance has contributed to the region being far from achieving the sustainable development goals. The Arab region has the highest youth unemployment rate worldwide, particularly among young women. In 2015, only 27% of women participated in the labour force compared 77% of men. Several countries in the region have established societal structures which substantially limit the access of women to political and economic life (ILO, 2017). The argument against recognising women's rights is related to cultural factors, stereotypes and a lack of rationality (ElSafty, 2003).

The crisis has equipped Syrian women in Zaatari camp with opportunities to better understand their rights. Prior to 2011, Syrian women thought it impossible to fight for their human rights, however with the exposure to different programmes and humanitarian agencies in Zaatari camp which address women's rights, some women have since obtained a sense of autonomy and become more independent (Sadiki 2014); this shift was also noted in the UNWomen report (2015).

Moreover, women's participation in voluntary and community work has helped in recovering their self-esteem and sense of identity, contributing to empowering them economically, socially and culturally as well as increasing engagement in decision making and better understanding themselves and their abilities (Asaf, 2017; UNWomen, 2017). A study of Syrian refugees in Turkey found that working and the professional status that comes with employment shifts women's personal priorities and enhances feelings of self-worth which in turn leads to a lower fertility rate and greater utilisation of family planning (Karakaya, 2017).

The displacement has forced a new way of life upon Syrian refugee women, with many living in Jordan reporting having a to take on a different role, being widowed, divorced or abandoned and becoming the main breadwinner and caretaker for their families (Asaf, 2017). This shift of traditionally male household responsibilities being taken over by women has in some cases resulted in physical and mental exhaustion, spurring women to participate in counselling sessions (Asaf, 2017; UNFPA, 2017; IRC, 2014). The camps have acted as a safety net during this time, and as reported by UNHCR, women have been provided with life skills classes including literacy, art and awareness sessions related to rights, reproductive health, child marriage and other protection related concerns (UNHCR, 2016). This has broadened their perspectives, as for the first time in their lives they have moved out of their homes, learned new skills, and many have started playing new roles. However, this leads to the questions of whether providing opportunities is the only way to ensure that women voices are heard, and what is needed for women to overcome barriers and to increase their ability to control and influence decision processes and results.

2.4.4: Risk of violence

Many studies are in agreement that gender-based violence is a contributing trigger that discourages health-relevant behaviours and decreases the uptake of contraceptives (Weber et al., 2016; Halle-Ekane et al., 2016; WHO, 2017; and Cole et al., 2015), especially in crisis, as a camp is not the expected safe haven for women and the incidence of domestic violence increases (Friedman, 1992). Elaborating further, a study by Dasgupta et al. (2017) in a slum community showed that 29.4% of women reported experiencing physical and/or sexual violence in the year prior to their pregnancy. A study by McCauley et al., (2014) revealed that in-laws in villages and rural areas in Côte d'Ivoire even encouraged their sons to use violence against their wives or deprive them of food if they disobey orders, including the order to have children. These findings were also identified by Annan and Brier (2009) in northern Uganda, where one out of every three refugee women were at risk of violence, including emotional and physical abuse, as well as unwanted pregnancies (WHO, 2017). From the evidence it is clear that women are not only influenced by spouses, mothers-in-law and the community, but in many cases are directly or indirectly forced to follow their orders due to living under pressure and the threat of harassment and violence.

A further examination of this complex situation shows women do not always object to the act of violence or unwanted pregnancies and on the contrary sometimes use justifications to normalise this behaviour, such as believing in the superior rights of men. This notion is in alignment with the findings of the International Centre for Reproductive Health in Afghanistan (2002), that showed 56.6% of the women believe that their husbands have the right to beat them if they are disobedient (K4Health, 2007), and 75.5% believe that their duty as wives is to have sex with their husbands, even if it is against their will (Freedman, 2006).

It is clear that there are various psychological factors that can influence uptake of reproductive health services among refugee women. Many of the studies reported here, however, are small-scale and limited to specific locations. What remains unclear is which of these psychological factors are significant in the context of Syrian women in Zaatari camp and to what extent. Without this understanding, efforts to improve uptake may prove unsuccessful, and a waste of much-needed money and time.

2.5: Environmental conditions

2.5.1: Consequences of displacement

Displacement causes significant economic and social stress, and at the same time makes it challenging for people to change their behaviour. Usually when people lose their livelihood and identity, suffer disruptions in service provision and are forced to live in poverty, reproductive needs become their lowest priority (Pierce, 2019). This impacts women's engagement with reproductive health care services in crisis situations, influencing women's ability to decide or act (Che Chi et al., 2015), and displacement often leads to an increase in maternal mortality rates (Pierce, 2019; Hach, 2012).

The feeling of unpredictability that comes with displacement is linked with insecurity among Syrian refugees. Many Syrian families in camps fear deportation or the withdrawal of access to cash assistance, and many also do not have access to information (IRC, 2017). This fear of

instability is ever present, and learning and financial vulnerabilities make Syrian refugees in Jordan incapable of planning for their future, and they make decisions based on what fits in their current context rather than following their wishes (JRP, 2018). This can also negatively affect their ability to access health services (UNHCR, 2015). On the other hand, the harsh conditions in the camp may encourage the uptake of family planning. In other places, such as among Syrian refugee women in Lebanon, women used the situation as an opportunity to have the courage to discuss limiting or spacing births with their husbands (Kabakian-Khasholian et al., 2017). However, other studies, for example in Turkey, confirmed that the migration had no impact on the desire of women to have more children, even women in labour expressed the wish to have more children (Tober et al., (2018).

2.5.2: Education opportunities

The low quality of education in the camp is a factor that drives women to marry and have children at an early age (Sieverding et al., 2018). Globally, higher levels of female education are associated with lower rates of fertility (Bledsoe et al., 1999). In Zaatari camp, the majority of women are educated to primary level (UNHCR, 2017). The percentage of registered girls in schools in the camp achieving a secondary school certificate is only 20%. The Jordan Response Plan (2018) referred to the low percentage of girls continuing their education, due to limited access to schools, the poor quality of educational provision, domestic violence, and gender inequality (HRW, 2017). While higher education opportunities for women in the camps are limited, women are dissuaded from seeking education outside the camp due to challenges in obtaining legal permission and barriers such as cultural restriction and high tuition fees. Moreover, sex education is not part of the accredited curriculum used nationally in the public schools, and inside the camp there are no pre-marriage counselling sessions available.

Limited educational opportunities for girls leaves them with minimal resources to express their ideas, beliefs and attitudes and enable them to negotiate regarding their reproductive health. The conceptual framework of women's status states that women's education positively affects multiple dimensions of empowerment, such as, decision-making power and attitudes towards social norms, and subsequently women with greater power have more control over their lives and futures (Shimamoto, 2019). Sieverding et al., (2018) also concluded that investment in girls' education is critical to the later age of marriage and correspondingly presumed fertility decline in Jordan.

Many studies conducted in similar contexts provide further support for the association between the level of education, empowerment and contraceptive use (Ahmed et al., 2010; Kishor and Lekha, 2008; Currie and Moretti, 2003). In Mexico, studies show that compulsory education for girls from sixth to ninth grade in 1993 contributed to increasing their knowledge of contraception and increased the likelihood of them using contraception (Andalón, Williams and Grossman, 2014). Another study in Nigeria showed that applying a universal primary education programme between 1976 and 1981 contributed to a reduction in the fertility rate. An extra year of schooling on top of primary resulted in women having 0.26 fewer children (Osili et al., 2008). While no studies have been conducted to understand the relationship between the uptake of contraception and level of education among Syrian refugees, Lee and Finlay (2017), in their analysis for the Population and Poverty (PopPov)

Research Network from 2006-2016, confirmed the association stating that expanding reproductive health utilisation improves women's agency and education, and increases labour force participation.

2.5.3: Economic status

Economic conditions can hinder or enable women's access to reproductive health care as was observed in Mali (Dennis et al., 2012), and further explored in studies in Korea, and Taiwan which found an association between the utilisation of essential health care among vulnerable groups and health finance subsidies (Leete, 1991; Ponsar et al., 2011). Afghan refugee women in Pakistan who received financial support for health care were seen to be more motivated to use contraceptives than others who did not have financial support (Raheel, Mehtab and Karim, 2012).

Economically empowered women who have the ability to succeed and advance, also have the legal and social standing to make economic decisions and to control economic resources (Hunt and Samman, 2016). This was demonstrated by Finlay et al., (2016) who found that women in Africa preferred to space births in order to be able to simultaneously care for the children and work at the same time. Not being able to work may have devastating consequence as this would remove financial stability and raise the risk of poverty.

2.5.4: Access to health services

With displacement, access to health care services becomes as important as shelter and education. Mengesha et al., (2017) state that in pre-and post-migration experience, a lack of understanding about health services and difficulties in navigating the health care system were reasons for an underutilisation of services. A study by Fahoum et al. (2015) states that Syrian refugees have access to a fairly good level of health services in Jordan, a country with one of the best health systems in the region with well-established services. However, this is not the case for Syrians living in the camp, of whom 75% stated that they did not receive sufficient health care services, though services were better than back in Syria. Specifically looking at reproductive health outcomes, a study by Hynes et al., (2002) stated that reproductive health outcomes among refugees in camps at the post-emergency phase were better than their respective population in the country of origin.

A weak health system with poor accessibility of services can lead to interruption, rejection or non-continuation of family planning methods uptake (Kerstein, 2015). A study by UNFPA stated that the satisfaction rate of reproductive health services is high among the Syrian refugees in Zaatari camp who visited the four reproductive health care clinics (UNFPA, 2015). In the same year, another study by Al-Fahoum (2015) stated that 52% of interviewees reported no discrimination during their stay in the camp, and that there were no communication issues with health providers or any other kind of concern when seeking medical care in the clinics. However, this finding means that 48% answered either neutrally or negatively. Krause (2015) concurred that women complained about the inadequately trained and unqualified health providers in Zaatari camp, and others complained about the quality of services, including disrespect and discrimination towards them by health workers. West, et al., (2017) stated that community led programme and training staff on culture sensitively skills are required in the camp.

Women's reproductive health is improved significantly when women interact frequently with healthcare workers (WHO, 2015). A study of family planning counselling conducted in northern Jordan outside the camp emphasised the importance of communication between health workers and Syrian refugees living there regarding contraceptive choices, as this contributes to increasing the use of modern contraception, protects women's rights and helps women to make an informed and voluntary decision regarding their reproductive health life. This was confirmed by another study in the camp by West et al. (2017) which stated that the presence of female staff increased uptake of family planning services and that the presence of health providers who perceived by the community as being disrespectful decreased the uptake of services. However, this was disputed by Okour, Saadeh and Zaqoul, (2017) who found that health providers encouraged large family size and promoted short-term contraceptive methods. What was agreed upon though was that women's behaviour is influenced by the personal beliefs of the health providers.

Building on this, a study of 425 refugee married women (18–50 years) in camps in Jordan revealed that 68.5% were concerned about the safety of using oral contraceptives and that 75% reported side effects, specifically headaches (Bardaweel, Akour and ALkhawaldeh, 2019). The researchers concluded that the unwillingness of women to use oral contraceptives was due to sizeable gaps in women's knowledge on how to use them. The study was qualitative and did not dig deep to understand the root causes of this belief, but it concluded that refugees held these misconceptions about side effects of contraceptives and poor knowledge of available services due to weak interventions. However, these concerns were also described by West, et al. (2017) who stressed the point that misconceptions surrounding contraception are one of the significant barriers to increasing the uptake of family planning tools.

According to the literature, stigma, fear, negative stereotypes and misconceptions limit the uptake of contraception (Asgary and Price, 2018; Herbert, 2015; Asgary and Price, 2019; Barot, 2017). UNHCR (2012) stated that in humanitarian contexts, apprehensions and misconceptions around family planning commonly block the utilisation of contraceptives in refugee camp settings. Some Syrian women in Lebanon were found to have a fear of infertility from the use of modern contraceptive methods, and others were concerned about potential intolerable side effects (Kabakian-Khasholian et al., 2017). The same study indicated that some men were against the idea of contraception use as they had misconceptions about the side effects and feared that their wives would be harmed. Syrian refugees in camps in Jordan also stated that they had a fear of possible side effects of contraceptives (West, et al., 2017). This situation is not an exception; in Uganda, research by Nalwadda et al., (2010), found that young people were afraid to use contraceptives as they believed it could harm their fertility. Another study conducted in Tanzania by Schuler et al., (2011), found that men were concerned that the use of female contraceptives would allow women to be unfaithful and promiscuous without fear of conceiving.

Additionally, in Zaatari camp, the literature reports that there are limited medicine stocks in reproductive health clinics and a long waiting times in public hospitals, all of which serve as factors that hinder women from seeking health care (Kerstein, 2014; Krause, 2015). The same issue has been reported in Bekaa, Lebanon, among Syrian refugees where limited supplies

and the inability to timely access supplies has been reported as a challenge (Kabakian-Khasholian, et al 2017). Both studies refer to a lack of supplies as a reason for the underutilisation of services, and this is also addressed in the WHO crisis response guidelines (WHO, 2012).

These guidelines also mention the importance of timely interventions. O'Donnell (2007) in his research explained that the timely use of reproductive health care according to demand has four dimensions: geographic accessibility, availability, acceptability and affordability. Krause (2015) reported that locations where family planning methods are available were limited in Zaatari camp during the early stages of the crisis. A UNFPA (2017) report confirmed that location and accessibility of services was addressed. However, Krestein (2014) raised the issue that there were no programmes established for post-natal care home visits in Jordan, meaning that it is likely that some women in the camp are not reached.

2.5.5: Community level initiatives

In conflict situations, Asgary and Price (2019) highlighted the need to invest in local initiatives from within the refugee community to raise awareness of and build trust around family planning and reproductive health services, and there is also a need to reconcile family planning services and reproductive rights within the social and religious context. However, Krause (2015) argued in her research that outreach activities were very limited. Apart from these few studies, there is limited published research on the effective, acceptable and culturally appropriate community-based interventions implemented inside the camp and very little examination of the impact of community-based interventions on the uptake of contraception in the camp.

2.6: Conclusion

The review of relevant published literature has helped to provide a foundation of knowledge about the factors hindering refugee women from exercising their reproductive health rights, with a special focus on humanitarian contexts. Analysing the evidence, it is clear that a range of factors could possibly be influencing women's decisions in the camp.

The literature review lists many factors that may contribute to a person's decision in addition to their knowledge, including culture, norms, religion, power dynamics, and the quality of services among others. However, only a few quantitative and small-scale qualitative studies have been conducted in Zaatari camp to try and understand the factors hindering women from utilising family planning services. These reasons are still not clear and the question of what is different in the camp context remains, and why some women utilise these services and others do not. This study will seek to provide a comprehensive answer to this question.

In answering this research question, of understanding the factors influencing the utilisation of family planning services, from Syrian women's and service providers' perspectives, the aim is to address the existing gap in knowledge, and to generate practical recommendations to enable the Ministry of Health and Humanitarian agencies working in the camp to enhance the reproductive health services and design a scientific based family planning programme that is effective and acceptable to the community it serves.

Chapter 3: Methodology

3.1: Statement of purpose

The purpose of this study is to explore the underlying factors which influence the utilisation of family planning methods by listening to the voices of Syrian refugee women themselves, by considering the situation from their perspective and by taking into account their understanding and beliefs. Moreover, to understand the situation better, there is a need to understand service providers' perspectives and their observations of the situation and dynamics in the camp.

This chapter outlines the methodology used to answer the research question. It describes the philosophy behind the research design, data collection, sampling, and data analysis techniques. Furthermore, the ethical measures implemented are stated.

The research question that guided the study is	What are the factors that affect the utilisation of family planning services among Syrian refugee women aged 18-49 years in Zaatari camp, in Jordan?

3.2: Research design

The research aimed to understand the process by which women make decisions related to family planning, their motivations, beliefs, potential risk factors and how outside influences can affect their decisions. It was also important to delve into the personal experiences of each woman, and how these led to the variety of decisions taken in relation to this subject, particularly how each woman may interpret the same phenomena differently.

Ethnography, or studying people in relation to their place and social interactions within the cultures they belong to (O'Reilly, 2009), was therefore selected as an approach for this study. In alignment with a study by Zahavi and Martiny (2019), a number of different perspectives were considered for generating and aggregating data, and in order to gain both a broad and in depth understanding of the phenomena in the context in which they exist.

There was a need to gather a variety of perceptions to identify the relationship between people's practices and their surrounding environment. Through exploring the way women perceive the utilisation of services and their experiences, it may be possible to identify links between these and actions taken (Seymour, 2016). Understanding the whole process is crucial: the perception of risk in the decision making process, what steps women take to utilise services, what the influencing factors are, and what makes them more able to understand their situation, form judgments in the context they are living in and realise the impact they have on the world around them and vice versa.

In this study, a qualitative research methodology was implemented to understand the challenges and motivations, from the women's perspective, that influence their decision or ability to access reproductive health services; this was expanded by exploring, from the

service providers' perspectives, the factors related to the existing family planning care services and the presence of an enabling environment for women to utilise services. Using this approach aids in exploring and explaining the meaning of the women's actions (Stellmach et al., 2018) and in generating broad concepts relating to: common values, culturally related beliefs, as well as more specific ideas related to behaviours, expectations and disparities among different women (Williamson, 2005). Moreover, this will allow direct engagement with women and service providers to develop discussions responsive to the participants' perspectives.

Since the topic of reproductive health and family planning is perceived as sensitive in the Syrian refugee community, as stated in chapter two, exploring participants' perspectives using descriptive, interpretative and explanatory elements provides the possibility to interpret participants' experience beyond the interview questions (Parker, 2012) and will help in better understanding the different perspectives of participants, and the construction of a meaningful sense of their experiences as perceived by them in their context (Thorogood, 2017).

According to Berger and Luckman (1967), the qualitative method has two approaches, one focused on individual construction and the other on the shared meaning that reflects social construction. Both can help participants to elaborate on their perspectives, in order to answer the research question more fully (Barbour, 2007). Both approaches can be achieved through interaction with participants individually and by listening to the interaction among groups of women to gain a deep understanding of the issue and generate a rich description of their personal experiences and reflections of the real life situation (Deheling and Rock, 2020). In this study, participants interpreted the world around them, made different assumptions, and shared information alluding to their own experience of the same subject.

A quantitative methodology was not considered as the research question was centred around an in-depth exploration of individual and collective experiences, rather than testing a theory; this required the establishment of a rapport with participants in order to encourage participants to open up when discussing such a culturally sensitive topic. Quantitative methodology measures knowledge, attitude or practice in a structural way (Bowling, 2002), and assumes that reality exists, and it can be represented using numerical data (Birchall, 2014) which was not applicable to this study.

There are many mechanisms of data collection in qualitative studies; interviews and focus group discussions are common methods to engage with the target audience and develop discussion to help participants to elaborate and share their perspectives on a certain phenomenon (Barbour, 2007; Silverman, 2013). The study methodology used in this study encapsulated both of these approaches: focus group discussions (FGDs) with 'women' and key informant interviews (KIIs) with 'service providers'.

The FGDs were chosen as the primary method in this study to obtain in-depth information and explore opinions regarding one subject from a group of participants who shared the same age group, background and interests (Deheling and Rook, 2020). According to Barbour (2007), this can be used as a way to access the opinions of marginalised groups. Deheling and Rock (2020) state that homogeneity among a group allows individuals to feel more confident in

discussing in depth views and in exploring further while retaining the cultural context. This is also confirmed by Barbour (2007) and Flick (2006) who emphasised that organising a FGD give researcher space to replicate the social and cultural contexts in which decisions and opinions are often formed and to understand how culture and interaction between women influences their decisions has an impact on their life. This is also the approach that was advised by social workers and Syrian community leaders in the camps upon consultation. FGDs allow the expression of a broad range of views and shared opinions relating to community beliefs, practices and behaviours, leading to reaching a common conclusion that reflects women's perspective in the community (Barbour, 2007).

As previously mentioned, family planning is a sensitive issue in the Syrian community, and therefore having FGDs may encourage women who are usually reluctant, to participate, interact and discuss the topic comfortably, exchanging views and thinking as a group (Morgan, 1988). According to Salmon et al., (2010) it may encourage them to overcome their shyness and start discussing personal matters in a group. Conversely, FGDs have the potential to compound the issue of reluctance, especially if women feel that their personal experience might be negatively interpreted or spread outside the group, which may lead to negative consequences and prevent participants from sharing their true opinions (Puchta and Potter, 2004). However, in relation to this study, as confirmed by community leaders in the camp, the women are all known to each other and meet on a regular basis; this social familiarity acts to mitigate the risks and challenges associated with talking about reproductive health.

FDGs may reduce the power imbalance between the researcher and the women which, if not addressed, could result in the women feeling uncomfortable and unable or unwilling to open up. FDGs will not put them in a position to justify why they think how they do, but rather give the group the opportunity to reflect and refine their views after discussion (Ritchie and Lewis, 2003; Deheling and Rock, 2020). However, it needs to be noted that some women may not feel comfortable to disclosure their stories or express an opinion if it is different from the rest of the group.

The researcher, in consultation with community leaders, considered the challenges of conducting FGDs and concluded that one-to-one interviews would not explore a shared understanding of factors but would instead allow an in-depth exploration on an individual basis (Samuriwo, 2010) hence the decision made to go with FGDs. This was reflected in the work of Benner and Tanner (1987), stating that FGDs generate a collective understanding, gathering multiple different practices and helping to identify common themes among groups in different contexts.

The use of KIIs with the service providers was selected as a research method to gain an understanding from the service provider perspective of the barriers, opportunities and challenges women experience when accessing family planning services. Using KIIs helped researcher explore to a greater extent, the unique personal experiences and insights from staff working in the camp on an individual basis (Samuriwo, 2010). It also offered a certain flexibility to learn more about and clarify the issues and concerns raised by interviewees (Carter and Henderson, 2005). Using probing questions to deep dive into the experiences of individuals is not possible when using focus groups.

Smythe (2010) highlighted that while interviews do not include direct interaction between participants, they help generate different perspectives and identify common themes. This enables the building of a picture around the research question through the lived experiences of multiple participants. In the research context, there was a need to understand the phenomena from different angles and take an in-depth view of the varied experiences of services providers from her or his own experience. FGDs were not chosen for this as each service provider had a different experience and worked in different places which would have been logistically difficult to organise and would not have fulfilled the objectives of the study.

The researchers utilised both methods of data collection, FGDs and KIIs, based on consideration of the advantages and disadvantages described above, building on the positive aspects of each method while mitigating risks and restrictions.

3.3 Theorical concepts

Using the Dahlgren-Whitehead 'rainbow model' as an overarching framework aided the researcher in designing the research tools and analysing the findings. It also helps to stratify the multidimensional range of factors that influence behaviour or social patterns, and allows the recognition of relationships between individuals, social community networks and the broader cultural, health and economic environment (Dahlgren and Whitehead, 2006). This model enabled the researcher to demonstrate how all of these factors are interlinked in the camp context, and illustrated how the actual choices made by the women in the camp or any other context are a very small component in determining their health (Warwish-Booth et al., 2012). However, the model does not give a detailed analytical description of the factors nor go into depth about the nature of interactions or coexistence of factors which influence health outcomes. Furthermore, it does not outline how changes in modifiable factors on an individual level influences the factors on other layers (Warwish-Booth, al. et., 2012), and therefore the researcher also used other models to support a more analytical description of the situation so as to enable the outcome to be better linked with strategies for improving public health.

As mentioned above, women in the camp live within a web of social interaction, which affects the decisions they take and their ability to space their pregnancies. The social network and dynamics within their family and community influences their opinions of and attitudes toward family planning. In the literature review, it was found that women in a humanitarian context are less able to manage their health and are more dependent upon family for their health and protection needs. Therefore, at each level of change the researcher identified potential influencing factors, building the argument and analysis on Luke's framework (1974, 2005) and 'negotiated order' theory (Strauss, 1978).

Luke's framework was utilised to explain the multi-dimensional social reality of power. Luke framed the power relation by defining three dimensions, or faces, of power. The first refers to the ability of a person to influence a decision-making process on an issue that may have observable conflicts of interest. The second dimension refers to a person or group consciously or unconsciously reinforcing an agenda that serves as a source of power over others. Lastly, the third dimension states that sometimes people act willingly in ways that appear contrary to their most basic interests, yet they act as though it is their wish. Their behaviours are built

on an unquestioned and accepted ideology and status quo, based on the evidence that it is the natural way of being. Luke's framework sheds light on the social mechanisms of power although it does not cover social features that may enable one individual or group to exercise power over another. In the context of this study, using Luke's framework offered the researcher a semantic analysis of the use of "power" in a certain community.

To be able to sociologically analyse the structural and causal reality of power, the concept of 'negotiated order' was used. This is an approach in sociology that focuses on everyday human interactions in small groups. It clarifies the possible means of getting tasks accomplished among parties, examining who speaks to who, in what way, in which sequence and to what result (Strauss, 1978).

3.4: Site selection

The data collection was conducted in two locations in Jordan: inside Zaatari refugee camp in Mafraq governorate where the women live and most of the service providers work, and in Amman where some of the service providers, especially those who work on the Syria response programme, live. It was decided to conduct the FDGs inside the camp for two reasons: first, because women are not allowed to leave the camp for security reasons, and secondly, because they feel more comfortable to stay in the area where they live. In addition, the venues selected for conducting the discussions with the Syrian women had been proposed by the humanitarian team who facilitated and secured several options of appropriate, relaxing and distraction free environments. The selection of venues was made carefully to prevent any possible psychological biases which could impact group interactions.

The two women centres selected were where Syrian women usually gathered to participate in handicrafts, sewing and hairdressing courses, and to discuss their daily life issues. Each centre had private spaces where social workers conducted listening and counselling sessions and where women were able to enjoy their leisure time in the morning when their children were at school. The women's centres have a good reputation in the camp and women from all age groups and different locations visit on a daily basis. These centres are one of the few places where women can get permission easily from their husband to spend time in. The women trust the team and the organisers in the centre, and moreover the centres are located within a safe space for women. Gender-based violence, reproductive health and youth services are located in the same place.

Prior to the interviews, the researcher consulted the community leaders and the participants as to the best venue to conduct the FGDs and visited all the locations four times to check the space and their appropriateness in terms of privacy, availability and security with community leaders and a security officer. The centres were secured, and the entrance was controlled by a guard, allowing only women to enter, and the security system of the place is linked to the public security department in the camp. The FGDs consisted of small group discussions with different age groups of women in one of the women's centres inside the camp, with a social worker present.

For the KIIs, each participant identified a convenient place to conduct the interview. Some of the locations identified were in participants' offices in Amman and others in the Zaatari camp.

3.5: Selection of participants

The sampling strategy used in this study was purposive; participants were selected based on characteristics of interest (Carter and Henderson, 2005). The selection of participants both 'women' (Syrian women ranging in age from 18 – 49 years in Zaatari camp), and service providers (health practitioners and social workers), was on the basis of convenience, according to needs of the study and who could provide the range of information required for the study. Selection criteria were established, based on characteristics of interest that ensured participates inputs were valuable to the study outcomes (Carter and Henderson, 2005). The researcher relied on the support of experts in the field when choosing, informing and inviting participants to participate in the study.

For the FGDs, the selection criteria were developed in consultation with the health practitioners at humanitarian agencies managing the reproductive health programme at Zaatari camp and later the criteria were verified and modified by Syrian community leaders in the camp. The selection criteria consisted of women of reproductive age who lived in the camp, willingly consented to participate in FGDs and could spare at least two hours to participate in the session. The full inclusion and exclusion criteria can be found in Table 2. The recruitment process was conducted culturally and socially sensitively with an emphasis on the voluntary nature of participation. Potential participants were identified by community leaders who live in the camp and had been working in the camp since its establishment in 2013. The community leaders identified and approached the women in their network who they believed to have the will and readiness to take part in this study. The community leaders informed the participants about objective of the study, where it will be published and other ethical and logistical related information.

With the support of the community leaders, the researcher met the identified women group by group at least once before the FGDs took place, to build trust and introduce the identified women to the rationale behind participation, the risks of participating in the research and the place where the findings of the study will be published.

Potential participants aged under 18 years were excluded from the study as recruiting children for research studies on sexual and reproductive health is a highly sensitive issue in the social-cultural and humanitarian context of Zataari camp, where involving young women in discussions on sexual and reproductive health is strictly forbidden. Women in the Zaatari camp are considered vulnerable in this context, while girls are highly vulnerable and extra measures are required to ensure their protection. Furthermore, their inclusion in this type of study could subject them to harm if their family or community perceived them to be sexually active outside of marriage.

Each focus group consisted of six women; the groups were segmented to keep women of similar age together, with the following age groups defined: 18-24, 25-30, 31-37, 38-44 and 45-49 years. The classification of age groups was carried out in consultation with health practitioners and social workers in the camp, who stated that women in the camp are divided into those who came as children and grew up in the camp, women who married in Syria and established their families in the camp, women who came with their children and completed their family in the camp and others who came with their complete family. The health

practitioners and social workers advised that, based on their experience in the camp to mitigate any potential of voices of divergence to be silenced, as young women are reluctant to speak about reproductive health issues in front of older women, especially as the older women are traditional grandmothers who had spent most of their lives in Syria. Culturally, young women are not allowed to discuss such sensitive issues in the presence of older women while the willingness of middle-aged women to discuss the topic varies depending on their background and the number of children they have.

KIIs were used to document the perspectives of social workers and health practitioners working on reproductive health interventions at three levels: working with families in the camp, managing the reproductive health programmes and from different agencies, bodies, and communities. Only service providers with three years total experience working with Syrian refugees, and at least one year's experience in the camp, such as direct work in family planning promotion, service delivery or policy formation, were selected.

Table 2: Inclusion and exclusion criteria for participants

Inclusion criteria:	*Focus group discussion* Women in Zaatari camp Women aged 18 – 49 years who willingly consented to participate in focus group discussions Women who are either using or not using reproductive health services *Key informant interviews* Health professionals and social workers in the reproductive health clinics in Zaatari camp Humanitarian workers working on reproductive health interventions at three levels (working with families in the camp, managing the reproductive health programmes and from different agencies/bodies/communities working in the camp). Participants must have a total of three years of experience working with Syrian refugees, and at least one year of experience in the camp
Exclusion criteria:	*Focus group discussion* Women who had mental disorders *Key informant interviews* Health professionals and social workers who were no longer in the position of direct contact with the refugees. Health professionals and social workers who had less than three years of experience in the Syria crisis, or less than one year of experience in the camp. Health professional and social workers who were less than 18 years of age, or who did not have experience in reproductive health care.

The number of participants was not defined at the beginning of the study. According to Sim, et al. (2018), sample size calculations are not necessary in qualitative research. The researchers decided to continue interviewing until saturation had been achieved, following guidance from Saunders et al. (2017) who suggest that saturation is a more important feature when conducting qualitative study than quantity of interviewees. This notion was also stated by Burmeister and Aitken (2012), who emphasised that reaching data saturation is about the depth of data gained and not the number of interviews conducted. Saturation is the point at which no new information is emerging from new participants, and no new codes or themes are being generated (O'Reilly and Parker, 2012).

In this study, the researcher achieved saturation after organising five FGDs; one FGD for each age group, where each FGD was attended by six women, and a total of 30 women participated in all FGDs. The KIIs included two gynaecologists, three Social worker, two nurses/midwives working in reproductive health clinics in the camp and three humanitarian stakeholders from humanitarian agencies working inside Zaatari camp.

The researcher provided potential participants with a Participant Information Sheet in Arabic about the study, a check list to indicate their consent with regard to sharing certain information and their willingness to participate voluntarily in the study. The researcher gave potential participants at least a week to consult with their families and decide before participating in the interview. Moreover, all women were encouraged to communicate with the community leader or researcher if they had further queries and concerns.

3.6: Study materials

Research materials were designed to ensure a systematical and rigorous process of data collection (Sofaer, 2002). An information sheet and a consent form were developed in simple Arabic language, clearly stating the objective of the study, the voluntary nature of participation, the risks of participation and the contact details of the researcher. It also included guidance for the participants on how and when they could withdraw from the interview, and their right to refuse to answer any question without providing a justification.

FGD and KII tools were developed for use by the researcher to help participants provide information in a structured and systematic way and to gain insights into participants' perceptions. Each tool included seven questions varying from general to specific. These questions were developed from the observations collected during the researcher's visit to the camp, the review of published literature and global strategies, and in consultation with experts in the field. Prior to the study, the questions were reviewed by a social worker in the camp. The design of the research questions was informed by a pre-determined Dahlgren-Whitehead 'rainbow model', to address and incorporate multiple levels of analysis of factors that influence health outcomes and take into consideration the interaction between individuals and their surrounding social and physical environment. The questions addressed the women's experiences, opinions, feelings, influences, knowledge and other qualitative variables related to their decision-making process or ability to access family planning services, particularly the impact of socioeconomic and cultural environment factors. The women in the focus group discussions were encouraged to provide any additional insights which were not covered directly by the question guide to help overcome limitations in the study construct.

Questions raised include asking what the process is and what would be the alternative option to consider, with the aim of understanding the dynamics surrounding decision making. Using the 'negotiated order' theory helped the researcher to link the ongoing interaction to social structure and between different levels, from small groups to the national level. However, the framework does not address the interplay between levels as they exist in society but rather examines them individually. To be able to have an overview of the negotiation, this study focuses on how interactions at family level are connected with community structures and overarching social discourses.

FGDs and KIIs interview schedules and topic guides were developed, reviewed and translated into Arabic. The questions were open-ended, clear, and not leading, yet were within a flexible framework. The flexibility of using semi-structured interviews enabled the researcher to stay focused on the main objective of the study, while at the same time remaining open to issues raised by participants (Carter and Henderson, 2005). All questions (table 3) were tested to ensure comprehension and acceptability by the community and were modified and revised after the pilot study.

The FGD guide included three main sections. The first was a warm-up consisting of general information about the participants themselves, the situation in the camp and general topics of interest to the participants. The purpose of this section was to put the women at ease and reduce any anxiety that the set-up may have caused (Legard, Keegan and Ward, 2003). The second part of the questions was related to attitudes, values and beliefs and knowledge related to the utilisation of family planning services. The third section examined factors that influenced their decisions whether it was at interpersonal level, for example husbands, mothers-in-law, mothers, peers, social factors referring to social norms, socio-economic conditions and values or structural factors referring to policies, legislation and services.

Table 3: Questions for the focus group discussions

Questions
In your experience, what do women in the camp think of reproductive health methods? What can women do if they do not want to get pregnant?
Have you proactively gone out to look for reproductive health services? What was the situation when you were in Syria? Can you compare the situation before with the situation now?
In your opinion, how do women in the camp find out about reproductive health services and how do they react to it?
Can you give me some examples of what kind of obstacles women face when they try to approach the reproductive health clinic? Were the services back in Syria better and, if so, how?
Can you describe to me the process of utilising family planning services? What are the positive and negative aspects experienced during the process?
Do you think women can decide when to become pregnant? Can you explain to me how easy it would be for them to do so?

What do people in the camp say about women who avoid or delay their pregnancy, women who use family planning methods? Can you give me some examples of what they say?

The KII tool included three main sections. The first was introductory about participants themselves and their experience in the Syria refugee response. The second part of the questions pertained to how they perceived the attitudes, values, beliefs, and knowledge of the women in the camp related to the utilisation of family planning services, and the third section looked at their perception related to factors that influence women's decision whether it was at interpersonal, social or institutional level. Finally, the closing questions addressed how they envisioned the situation and what they would recommend to enhance the reproductive health service delivery in the camp further based on their experience.

Table 4: Questions for the key informant interviews

Questions
In your opinion, how do women in the camp get to know about reproductive health services and how do they react to it?
In your experience, what do women in the camp think of reproductive health methods? What methods do women use to delay pregnancy? Under what circumstances does that happen? Do they proactively go out to look for reproductive health services? From your experience in the field and observation of the women, was the situation back in Syria better?
Do you think the reproductive health policies and strategies in Jordan support the reproductive health intervention in the camp? Can you elaborate and explain to me how it may help?
Do you think strategic planning has helped increase the utilisation of family planning services in the camp, and if so how? What is the value of having coordination and reporting mechanisms?
In your experience what kind of obstacles do women face when they approach a reproductive health clinic? How do the women in the camp compare the services in the camp vs back in Syria? Can you give us examples?
Can you describe how women access services in the camp? What is bad and good about the process of obtaining services?
Do you think women can decide when to get pregnant? Can you explain to me how easy it would be for them to do so?
What do people in the camp say about the woman who avoid getting pregnant? Or the women using family planning methods? Can you give me an example of what they say?

3.7: Ethical considerations

The purpose of this research is to clarify, explain and elaborate on women's private experience an intimate/very personal aspect of their lives, and therefore the researcher carefully considered the ethical implications during the preparation, implementation, documentation and dissemination processes.

3.7.1: Ensuring the quality and integrity of the research

The researcher pre-tested the study tools before the full-scale study and adjusted them based on the results of the pilot study. During the pilot phase, the researcher examined the study's method and procedures, evaluated any ambiguity in the questions, tested the flow of discussion, time, feasibility and the questions' reliability and sensitivity. The original tools were formulated after reviewing the available literature and relevant publications, and the process of development carried out in consultation with reproductive health experts and in participation with Syrian refugee women community leaders (gatekeepers); they were later reviewed by a reproductive health expert and modified again.

In the study, the researcher focused on understanding the factors and the challenges that hinder Syrian women in utilising family planning methods to space their deliveries. The findings of the study will be translated into recommendations for humanitarian agencies working in the camp, that they can use as a reference to enhance women's wellbeing and promote their development in the camp, and potentially could contribute to improving the health and development of the Syrian community and society in the camp.

The researcher sent the protocol to relevant United Nations agencies who manage the reproductive health clinics and women's centres in Zaatari camp, and who interact with Syrian women on a daily basis. The researcher conducted on-going consultations with reproductive health professionals and decision makers to ascertain the value and benefit of collecting data versus the risks this research may pose to individuals in the camp, and the practical contribution it could make to the women's life and well-being.

A brief note in Arabic was sent to the camp's manager and reproductive health working group to ensure their support and protection throughout the implementation process of the research. Moreover, the researcher sent the study's ethical form to the management of the camp for information only. The form included the research protocol, participants' consent forms, participants' information forms, the interview guide and interview schedules. No formal ethical consent form was requested by the camp or the United Nation agencies and the interviews and focus group discussions were conducted in accordance with the United Nations ethical principles of reporting and code of conduct. Finally, the researcher has been advised by decision makers at humanitarian agencies and community leaders to avoid using the term 'sexual reproductive health' and sabstituited it with family planning or reproductive health services as the first is culturally not acceptable to use at all levels.

3.7.2: Avoiding harm to participants

Given that the topic of the study is very sensitive and personal, the researcher sought the support of service providers and community leaders at the camp to identify the potential psychological, security and social risks at individual, family and community levels and to propose the best mitigation measures to minimise the chance of adverse events occurring. The researcher observed and learnt that the community in Zaatari camp is very conservative and that sexual reproductive health is not an easy subject to discuss. Based on the advice of community leaders and social workers, the researcher was mindful not to push participants to discuss things that could distress or offend them during the interviews, and not to raise any questions that could expose participants to trauma or discomfort. Moreover, the researcher,

with the support of the community leader, selected appropriate questions and language (accent) for discussing sensitive issues. Throughout the process, the researcher was careful not to affect the participant's personal life negatively (intentionally or unintentionally) or to interfere in the women's personal life or relationships with their husband or any family members. The researcher sought to avoid putting participants in any vulnerable position by obtaining on-going informed consent (Kaiser, 2009) and by re-obtaining consent at the end of the FGD as a persuasion measure to help participants to maintain privacy regarding the content of the FGD and to emphasise the voluntary nature of the study (Hoskins and White, 2013).

The researcher sought to have a social worker, who is a psychologist and counsellor, present in the interviews as an observer, if agreed upon by participants, to ensure that no one was put at risk throughout the process of the study. The social workers at the centre are trained to identify gender-based violence survivors and apply case management measures, using the referral guide and standard operation procedure. The researcher offered listening and counselling sessions to women who experienced distress due to participation, and provided them with contact details if required.

At the end of the interview, the researcher provided the participants with information about the services, support and activities available in the centre, which women can access for free. The participants were reminded by the researcher of the importance of participating in the biweekly community meeting and of the hotline where they can share their experiences and expectations. The researcher asked the participants about how they felt after their participation in the study and sought to obtain feedback in order to improve the experience of the FGDs. Most of the feedback received was positive, and a recommendation was given to add more questions related to the accountability of service providers, which was not in the scope of this particular study.

3.7.3: Ensuring voluntary participation

The social workers are trustworthy and have been in the camp since its establishment; they are familiar with most of the women and their families, and they can play the role of caregiver. To ensure that the research process would not harm any of the participants, the researcher asked the social workers at the women's centres to identify and approach women prior to the study (from women visiting and not visiting the centres), to introduce them to the rationale and risks of participating in the research and to give them at least a week to consult with their families. The researcher sought the support of the social workers to be introduced to the women who showed interest and decided to participate in the research.

The researcher made it clear for women that their participation was voluntary and that they were not obliged to take part in the research. It was also important to emphasise that their access to health services and the quality of service they received would not be affected by their decision of whether or not to participate in the study.

To ensure confidentiality for the women participating in the study, the researcher notified the humanitarian agencies managing and funding the services provided in the camp to implement any relevant measures and discussed this with the sub-working group, who are mandated to maintain and assure the provision of equitable and accessible services to all refugees inside

the camp and to ensure the protection of women. The institutions who manage services in the camp are committed to providing services to all refugees equally and they are under close and regular observation and auditing, and the teams at the women's centres are trained in ethical principles and human rights issues.

3.7.4: Informed consent

Prior to collecting the data, the researcher visited the identified women in a neutral place, the women's centre, where usually women feel comfortable and relaxed, in order to build trust, develop personal relationships with participants and break down communication barriers. The researcher discussed day-to-day issues with the women, such as the number of children they have, how they manage their time, how they divide their attention between house, spouse and children, how they prepare for traditional wedding celebrations and what is the role of mother and mother-in-law in the Syrian community. The researcher explained verbally in a simple Arabic language the objectives and nature of the study, the risks of participating in the research, where the findings would be published, and how the results would be used. Moreover, the researcher distributed an information sheet about the different aspects of the research. The researcher assured participants that all data would be protected and anonymized, and that personal information would be kept confidential (Bowen, 2005).

Obtaining informed consent was a continual process of negotiation on several levels. The participants each received a consent form which included a checklist to help indicate any potential reservations with regard to sharing information and their willingness to voluntarily participate in all stages of the study (Polit and Hungler, 1998). The researcher explained the content of the consent form and clarified to participants that they had the right to decline to answer any question at any time. Moreover, they had the right to withdraw from the interview before it took place or after.

After obtaining both verbal and written consent (informal as well as written) and prior to collecting data, the researcher discussed the preferred time and location for the FGDs with participants to find where they would feel most comfortable and safe, and asked for permission from each participant to record the discussion. The initial proposed location based on the researcher's experience, site inspections and after initial discussion with social workers in the field was the women's space. Women of various age groups who both use and do not use contraceptives gather here during their leisure time. The location decided upon by the participants themselves was the women's centre which provides the women with a space to share their personal thoughts and experiences away from their family members and in a private setting.

3.7.5: Respecting confidentiality, privacy and anonymity

Discussing sexual and reproductive health issues in a conservative community such as Syrian refugee population is rarely done. Sexual education does not exist among the Syrian community and talking about the uptake of contraceptives is not a normal or common topic of discussion. On the contrary, they consider this as a sensitive, private and undiscussable issue. Therefore, the researcher endeavored to respect participants, their values, beliefs and preferences by understanding their profile and taking advice throughout the process from the community leaders so as not to offend or upset any of the participants.

Qualitative methodology requires the collecting of detailed personal information which must be kept confidential. In order to ensure that no personal information is leaked or passed on, the researcher developed a data collection strategy, taking ethical principles into consideration and applying a no harm approach during the interview and documentation. The researcher reminded participants before the interview started that the discussion would be kept confidential and asked them to respect this.

All data was anonymised; the participant's names were coded and replaced with pseudonyms, and any components that could potentially describe participants' personal life or could reveal participants' identity were removed (Houghton et al., 2010). The researcher consulted with the social worker, who recruited the participants, to ensure that any data collected before starting the analysis process would not directly or indirectly harm any of the participants. The participants were informed that data would be stored safely, and that all information would be anonymised.

The researcher is trained in the referral and case management system inside the camp on how to report to the focal point in the reproductive health sub-working group with regards to any illegal or dangerous health practices, so that accurate advice could be provided. If any issues relating to gender-based violence were identified, the researcher would have notified the social worker to follow up with any actions required. During the data collection, only one woman was referred to the reproductive health sub-working group and none reported to the social worker. The participants were also encouraged to participate in activities in the women's space, where psychological support services and lifestyle/recreational activities are provided free of charge by trained counsellors.

The participants received information in writing pertaining to the persons who would have access to the data and how the information would be used. The researcher saved all data, transcripts, and original files in a personal laptop with a secure password which was only otherwise accessed by the academic advisor. All copies of electronic data were stored securely on the university's X drive.

The hardcopy of transcripts or notes in Arabic and English was destroyed after transferring data into electronic files. The researcher destroyed all personal data at the end of the analysis with the exception of the consent forms, which will be stored for 12 months after the study ends.

3.7.6: Protection of the participants and researcher during data collection

The security situation inside Zaatari camp is unpredictable, and a few incidents of violent fights and riots have been reported inside the camp. The researcher is a member of UN staff, and the UN Security Management System (UNSMS) ensures the safety, security and protection of staff during visits to the camp. The researcher was in direct contact with the United Nations Security Section and Public Security Department in Jordan and moved around in a United Nations vehicle and utilised United Nations facilities inside the camp which are secure and protected. If any incident were to have occurred or risk arisen, the security office in the camp would have intervened immediately and secured a smooth evacuation of the United Nations staff members. The researcher obtained security clearance prior to visiting the camp from the public security department and was equipped as a United Nations staff

member with communication tools linked with the security office in the camp to provide Information about any external approval requirements. Previously, the researcher had been trained in advanced security in the field and had more than ten years of experience working in emergencies.

The researcher approached the camp manager office seeking its support to review the names of participants to check whether any of the participants had a security issue and requested the security team's support in protecting the location for the FGDs. The researcher stayed in contact with the camp manager and the United Nations security officer to ensure that all security measures were implemented during the process of collecting data.

In addition, the researcher dressed appropriately and maintained cultural sensitivity to the Syrian context and situation and learnt about the culture and traditions prior to the visits.

3.8: Data collection

The research protocol was sent to relevant agencies who managed the reproductive health clinics and women's centres in Zaatari camp. A brief note in Arabic was shared with the centre manager, health professionals and social workers and community leaders (gatekeepers) in the camp.

The length of FGD was approximately 45-60 minutes. Each was followed by an unrecorded discussion of personal issues related to the number and age of children and level of education of each participant. The researcher did not record this portion of the discussion to assure privacy, respect the will of participants and build trust. To maintain data confidentiality, the FGD involved only a small number of participants (Sim and Waterfield, 2019). Prior to commencing the discussion, the participants were briefed again in a simple Arabic language on all aspects of consent and the right of participants to withdraw from the FGD before starting and to decline to answer any question at any time during the discussion. Participants were asked to repeat these caveats on consent to ensure that they understood and were willing to participate voluntarily. After obtaining consent (informal as well as written) the researcher asked for permission to audio record the discussion. The researcher also informed the participants that they could inform the community leader for up to two weeks post discussion in case they changed their minds and would like their input to be discarded.

The length of each interview was approximately 60 minutes. All interviewees were briefed about the study and an appointment scheduled for each interview. Consent was obtained and the ethical procedures applied for the focus groups were applied here too, for example the right of interviewees to decline to answer any question, at any time during the discussion, and withdraw from the study up to two weeks after the interview.

The focus group discussions and interviews were conducted in Arabic, the language of the Syrian refugee women, and transcribed. According to Lapadat and Lindsay (1999), transcription is an essential process in qualitative analysis and an important step to achieving accuracy and retrievability. Afterwards, the transcripts and notes were translated into English by a certified translator who is familiar with both the subject and terminologies used. The final English version of the text was compared and reviewed by the researcher and cross

checked by one other analyst recruited to ensure responses were consistent and the translation was accurate.

A total of ten service providers (health professionals and social workers) were interviewed between February and April 2019, and 30 women who were living in Zaatari camp participated in five focus group discussions (FGDs) between February and May 2019

3.9: Pilot testing

A pilot study was conducted to review the interview questions and evaluate the effectiveness of the process and tools. The pilot study consisted of two FGDs, each involving six Syrian women, and three key informant interviews with health professionals. This provided opportunities to revisit the protocol, obtain feedback, identify gaps and examine the methodology prior to conducting the full-scale study. Moreover, it helped to test out the flow of the questions, revise the instrument, check the participants' level of understanding, pick up any language difficulties, and check that the output of the discussion would contribute to answering the research question (Teddlie and Tashakkori, 2009). Before the pilot study, a successful application for ethical approval was submitted to the Research Ethics Approval Committee for Health (REACH), University of Bath, along with the interview guide and consent form. The approval process deepened the understanding of what needed to be achieved and the measures to assure the application of ethical principles throughout the study.

According to Teddlie and Tashakoori (2009), conducting a pilot provides the researcher with the opportunity to test the tool, whether it generates appropriate data and if the questions are easily understood by participants.

The pilot study revealed many issues related to cultural factors and the impact of displacement, that might influence participants' practices in relation to family planning. Engaging with participants during the initial stages, in their own language, gave the researcher a deeper understanding of how they perceived their situation. This first-hand interaction also helped overcome challenges, such as convincing participants to record their voices, something the majority were initially against.

All observations from the pilot study were considered in the full-scale data collection process. No problems were identified with regards to the clarity of the questions, however the interview schedule/topic list, and other factors relating to engagement with the participants, were revised throughout data collection, particularly in the early stages. No comments, observations or feedback were raised during the pilot phase by participants of the KIIs.

Conducting the pilot study enhanced the researcher's ability to ask probing questions and let the participants elaborate more on the topics under discussion. It was found that more probing and follow-up questions needed to be asked to generate richer data and give the participants space to disclose personal information, interact, get engaged together and talk more about culturally related issues.

Transcribing the interviews and translation from Arabic to English during the pilot highlighted the importance of checking the translation and ensuring it matched what was said in Arabic.

Coding the raw data helped the researcher segregate and systematically classify the data collected. This not only gave a fuller picture of how comprehensive the discussion was, but it reinforced many earlier observations from visits to the camp. It highlighted the fact that considering different age groups of participants was very important for the analysis, as the thoughts and beliefs of each group were linked to the amount of time they had spent in the camp relative to the time they had lived in Syria.

Conducing the pilot study helped with overall study management, as the researcher organised and practiced focus group discussions, and facilitated participant engagement in discussions prior to launching the full study. Conducting a pilot study helped in identifying practical procedures to ensure the full engagement of all relevant teams in organising the FGD, such as obtaining clearance from the United Nations security team, clearance to enter the camp, techniques to approach and identify the right participants and improved ways to conduct the interview.

The pilot study helped in developing a relationship with service providers in the camp. Visiting the camps more than four times prior to conducting the pilot study allowed the researcher to examine the venues where the interviews would take place, and moreover it gave the researcher an opportunity to meet participants prior to the FGDs and build trust which laid the foundation for participants feeling more able to open up and share their personal experiences during the discussions.

Preparing for the pilot study also required meeting the representatives of the two organisations working on reproductive health services in the camp. During the meetings, the objectives of the research were introduced. The anticipated outcome, how the findings could enable an improvement of services inside the camp, was also presented. This was also an opportunity to get high-level support from the management, which facilitated aspects such as security, logistics, and getting access to safe spaces to conduct the interviews inside the women's centre.

3.10: Data analysis

The interviews utilised open-ended questions in a semi-structured format during which the researcher listened to answers, asked for more explanation, and recorded responses. The English translation of the discussions was entered into Analysis software (NVivo) for thematic analysis. This software, which according to Welsh (2002) is an excellent resource for managing and organising large data and supporting the process of analysis, was also used to document sources, observations, published research and notes. The nodes tab was used as a container to hold coded materials and to streamline the data by dissecting the transcripts into meaningful segments (Welsh, 2002).

3.10.1: Data analysis plan

The researcher went through levels of analysis, moving from general to more specific to gain a better understanding of the issues and the reasoning behind them, and to reveal critical and strategic insights to address barriers and identify possible solutions to overcome them (Wainwright, Boichat and McCracken, 2014).

A thematic analysis approach was used to synthesise codes into themes (Braun and Clarke, 2006). According to DeSanti and Ugarrize (2000), thematic analysis helps in identifying common threads from a set of interviews and is a flexible approach that allows the researcher to use a thematic framework to guide analysis. The application of this approach is essential for maintaining the validity of the research as it requires the researcher to rely more on describing the findings (Attride-Stirling, 2001; Sandelowski and Barroso, 2003). It allowed the researcher to explore deeply the factors that influence the women's decisions, to determine the relationship between concepts and opinions, and constantly compare the data collected (AIhojailan, 2012). The phases of developing the framework for analysis began with becoming familiar with the data, creating initial codes, searching for themes, establishing a network, exploring thematic networks and finally summarising the outcomes (Braun and Clarke, 2006).

3.10.2: Familiarisation with the data

The researcher read all the transcripts multiple times to get familiarised with the data collected and to identify preliminary patterns, concepts, words, phrases and ideas (Riessman, 1993). Listening to the recordings also enabled the researcher to verify the accuracy of the transcript. The researcher sent the files to a professional analyst in the area of health who has a research background, to go through the transcripts and to verify the accuracy of translation and transcription.

3.10.3: Generating initial codes

Prior to the analysis, the researcher deductively created rough nodes (key words) guided by the initial reading of the transcripts, the family planning literature, theoretical model and notes generated during the interviews (Braun and Clarke, 2006).

Using the NVivo software, the researcher examined the most frequent words mentioned in the interviews and discussions to ensure that they were reflected in the list of nodes created. The top ten words related to the question of the research were already in the list, namely women, family planning, husband, mother-in-law, decision, services, and pregnant. Later on, the researcher again read the interviews multiple times to gain an in-depth overview of the data collected and started inductively labeling statements that summarised potential drivers. The researcher applied a coding process starting from generating initial codes, themes, reviewing themes to defining and naming themes (see table 5 below).

Table 5: The coding process

Phase 1	Generating initial codes
Phase 2	Searching for themes
Phase 3	Reviewing themes
Phase 4	Defining and naming themes

The researcher used latent thematic analysis (Braun and Clarke, 2008) to extract codes. This process involves some interpretation of the words spoken by participants, and the interpretation of the meaning of the text was based on the researcher's experience and knowledge of the situation and the Arabic language.

According to Bazeley (2009) when using semi-structured interviews and open-ended questions, extra themes may emerge. Throughout the process, the codes were modified and reorganised to reflect the structure of the collected data. The researcher examined each code and identified all concepts that could be associated with it. The researcher repeatedly reviewed the original transcripts and research question to maintain focus and to make sure that the refined codes covered all aspects comprehensively. Initially, the researcher was able to identify 90 nodes through the coding process, example of codes in the table 6.

Table 6: Examples of codes from the study

An example of coding two sentences that have the same meaning is as follow:
Participant A "They are now more interested in using IUD, that was so rare before… They are directed more to the IUD and the pills. They consider the IUD as a long-term solution."
Participant B "There is an increasing demand on IUD. Women ask for the IUD. Women who use the IUD and feel comfortable, they go and promote the IUD among their community."
The two sentences coded as "personal preference"

The researcher wrote a short description of the key interpretations in each passage and assigned a colour for each code for easy reference and to maintain consistency during the analysis. Codes were related to substantive items such as behaviours, values, beliefs, choices, emotions and other elements such as perceptions of health services and social norms, in addition to the community and family influences.

3.10.4: Searching for themes

After completing the first batch of transcripts, the researcher again reviewed all codes generated, and grouped together codes into themes, see example in table 7. Using NVivo, the researcher looked visually for connections between codes and sorted codes into categories by drawing a mind map.

According to Braun and Clarke (2006), writing the name of code and visually organising and reframing them structurally into themes is helpful. Each theme pertained to one idea that was expanded into a broader concept (Attride-Stirling, 2001). The researcher reviewed each transcript separately and started identifying and studying the relationships between codes, themes, and levels of themes.

Table7: Examples of themes from the study

Example of themes	
Possible coding	Possible coding
Preferences	Reflections
Possible theme	
Behaviour	

The researcher shared the list of codes, themes and transcripts that had been coded with experts in the field for validation, feedback and guidance. The initial set of codes was agreed upon in collaboration with the academic advisor and experts and applied to all subsequent transcripts.

3.10.5: Characteristics of the datasets

Qualitative data analysis is an interactive and non-linear process, and the researcher kept continually reviewing, refining, combining and categorising codes until underlying patterns began to appear (Attride-Stirling, 2001). A list of four broad themes and 12 sub-themes were identified for the more in-depth analysis after comparing these with the original research question and theoretical framework as shown in table 8. The themes were developed after analysing the narrative data generated. From this, common topics were identified and grouped under sub-themes related to certain phenomena (Miles and Huberman, 1994). The themes identified sought to address the research question regarding the main factors related to utilisation of family planning services among Syrian women in the camp. Following the guidance of Attride-Stirling (2001), the themes were specific enough to be discrete and broad enough to capture a set of ideas. The coding enabled the researcher to systematically explore similarities and differences among focus group discussions (Charmaz, 2010).

Table 8: Summary of themes, sub-themes and codes which emerged through analysis

categories	Sub-theme	Themes	Code related to
Tradition and beliefs	• Tribal culture • community expectations and pressure • Inherited beliefs and behaviours	Social norms	Community

Family dynamic	• Family interference • Mother/Mothers-in-law • Spousal communication	Family influence	Interpersonal
Social exclusion	• Camp context • Women's rights • Lack of knowledge	Behavioural	Individual
Availability of family planning services	• Back in Syria • In Zaatari camp (at the beginning of crisis • In Zaatari camp (Present)	Structure formal and informal	Organisational

The researcher constructed a thematic network by exploring the relationships between codes, between themes, and between various levels of theme (Braun and Clarke, 2006). Using such a network provided a tool to explore and dive deeper into the meaning of the texts (Attride-Stirling, 2001).

3.10.6: Describing and exploring the thematic networks

The researcher explored the emergent themes further to start understanding the patterns (Attride-Stirling, 2001) and later generated a matrix summarising the data from each transcript while taking care to retain key information, impressions and meaning from the original text. Drawing from the ongoing analysis, the researcher wrote analytical memos and constructed a model that reflected the major findings. Using NVivo, the researcher summarised the findings and examined the relations between multiple forms of data.

For example, looking at the knowledge about available services and family planning methods, below are some statements coded from two focus group discussions and one key informant interview.
Women, age group: 18-24 years:
• There is no formal sexual education before the age of 18 years; • There is no evidence that they would be encouraged to engage in family planning at this age from their community. i.e. mothers, mothers-in-law, sisters, sisters-in-law etc.; though they would know about the services mainly from their community; • Women are aware that all services and awareness sessions are provided by the international community organisation.
Women, age group: 30-35 years
• Women are proactive in seeking the information and services; • There is maturity evident in taking decisions about choosing available family planning methods; • The women at this age are aware of the main concepts of family planning and the availability of services.
Service providers

Lack of sexual education is evident; though progress is noticeable over the past 7 years of work; Misconception of different issues about family planning is evident, for example, breastfeeding is the best method for family planning. The misconception is addressed through different awareness sessions; Primary source of information for the refugees about the availability of services is by word of mouth (by relatives, neighbours and friends) and home visits from the community service.

Interpreting patterns

The researcher started interpreting the patterns that emerged from the explored text looking at both the original research questions and the theoretical interest (Attride-Stirling, 2001), summarised the findings under each theme and narrated these into a cohesive story to answer the original research question. Quotations were selected to illustrate the themes which were identified. The researcher used triangulation methods to develop a comprehensive understanding of issue by capturing different dimensions and presenting perceptions from the women and service workers. The findings of the study will be presented in the next chapter.

3.11: Reflexivity

Reflexivity is the active process of reflecting on how the beliefs or assumptions of the researcher may impact the processes of data collection and data analysis. I have more than 22 years of experience working in health, social work, and protection in humanitarian contexts, four of which have been centred around the Syrian crisis, specifically on reproductive health and gender-based violence. Having the practical experience in the field and being familiar with crisis situations and refugee camps (Zaatari camp in particular), and their negative consequences for women and children, helped me to understand the dynamic characteristics of individuals, families, societies, and the environment where the women access family planning services.

I am a social norm and behavioral specialist working in a humanitarian agency (UNICEF) that is very well known in the camp. My work focuses on project management, critical thinking, analysis and communication, developing and implementing national workplans, writing strategies, conducting research and supervising studies. In this study, my position helped me to become familiar with the procedures required to conduct the research, the history of how services are delivered, and policies and procedures implemented, and to build trust with the participants over a short period of time. My proximity also made it easier to break the ice with participants and laid the foundation for women to open up and share their personal experiences.

Being a regional trainer in gender-based reporting and children's rights-based journalism helped me to be objective, to focus on the research question and avoid mixing professional

and personal beliefs, and to apply ethical principles of interviewing and reporting during data collection, reporting and discussion. During the FGDs in the pilot study, I had to consciously push myself to remain in a neutral role, especially when hearing stories that demonstrated gender inequality or observing how often women were prevented from accessing opportunities. I overcame this by practicing ethical interviewing skills gained through previous experience in interviewing gender-based violence survivors. Practicing these skills helped me to control, manage and respond to queries professionally.

As the utilisation of reproductive health services is a sensitive topic, being an Arabic speaker from the same region as the participants was of great advantage as it not only saved the time of digesting the context, traditions and dynamics of how Syrians live, but also contributed to understanding the meaning behind each statement and the nuances of Arabic words and phrases used. This enabled me to feel closer to the women and being able to all speak our native language and share common concerns created a comfortable environment for both the participants and I.

I was keen to respond to direct queries from the participants, whether by referring them to services or providing them with advice after the interviews and focus group discussions were completed. During the entire process I clearly communicated that I did not have a role in service provision, never made promises and remained focused on the objectives of the study. It was necessary to encourage participants to be honest about their opinions and experiences and at the same time assure them that their participation would not block or facilitate their access to service provision. Clarity and transparency were deemed necessary to avoid any possible bias in responses, to mitigate the unequal power distributions between the participants and I, and to facilitate a comfortable environment for discussion.

Since I had previous experience working in the Syrian crisis profile, at the beginning of the study I had some assumptions about the legitimacy of the rather traditional and conservative views that seem to have influenced the Syrian womens' uptake of services. To overcome this, I challenged myself to step out of the mindset of being a liberated, Westernised, professional working for a humanitarian agency and living in the capital, and be more objective and scientific throughout the process. Gradually, I did my best to identify potential source of bias and sought to minimise this by reading literature from similar contexts about factors which influence women's decisions and continually revising and questioning myself in each step. Examine the literature on related topics such as empowerment and globalization enabled me to think these with practical professional practice and further improved my ability to be objective and scientific.

I faced some other challenges given that I am a part-time student working in a humanitarian agency. For example, many unpredictable incidents occurred during the study which required me to put the study on hold while I responded. During the data collection, there was a strong rumour in Zaatari camp that services would be cut as a result of funding shortages and that the Syrians might be deported back to Syria. Due to this I delayed the data collection until the issue was resolved, so as not to affect the data quality. Later during the analysis and writing-up process, many social issues arose, and recently the Covid 19 pandemic required me to free myself completely to support the government in its response. Another challenge I encountered was related to discussing the quality of work and services in front of service

providers who either work with other United Nations agencies or partners funded by the agency itself. This was uncomfortable but I made conscious efforts to remain neutral and professional.

I was uniquely positioned to conduct this study, through my professional expertise, cultural suitability and having access to the opportunity to work in Zaatari camp. Through being self-aware and adaptable, I was able to overcome the challenges which arose while carrying out this research, and gained a wealth of knowledge and insight, both into the subject area and myself.

Chapter 4: Findings

This chapter presents the findings from the five focus group discussions with the women in the camp and the ten key informant interviews with service providers (health professionals and social workers). The discussions and interviews were all aimed at exploring the factors that affect the utilisation of family planning services among Syrian refugee women in the camp. The findings are presented according to the themes and sub-categories established following the process of data analysis described in Chapter 3. Eleven sub-categories are presented grouped into four main themes: tradition and beliefs; family dynamics; social exclusion; and availability of family planning services.

Socio-demographic data of interviewed women

For this focus group discussions, 30 women aged between 18 and 49 years old were recruited. All participants arrived from Daraa in Syria between 2011 and2013 and they belonged to Bedouin tribes, an ancient farming community who live across many small towns. There tends to be strong relationships across and within these communities, and a conservative culture. All of the women were officially registered as refugees, and the majority of the participants were married, while a few were widows or separated, and one was engaged. All except one have children, with the number of children per woman ranging up to 11. Most of the women have been educated to primary level, and only a few held secondary education, and those who did were working as volunteers in the camp.

For the key informant interviews, the researcher interviewed two gynaecologists, three social workers, two nurses/midwives working in reproductive health clinics in the camp and three humanitarian stakeholders from humanitarian agencies working inside Zaatari camp. Three workers were based in Amman, while the others worked inside the camp.

4.1: Tradition and beliefs

4.1.1: Tribal Culture

The study found that tradition and culture hold women accountable for maintaining the tribe's status quo of having a large family with predominantly male children, and this is one of the factors influencing the utilisation of family planning services. The researcher observed that with displacement, the community has become more tied to tradition and keen to maintain and retain cultural values and identity as a reminder of their lives back in Syria. Women are partaking in traditional practices, including those related to family planning, as it gives them a positive sense of belonging to their lands and tribes and helps them maintain their status in the new community they now belong to. Meanwhile, service providers see that it is challenging for them to promote family planning services as it seems to contradict traditional tribal values.

Below are the main three subthemes under “tribal culture”.

Desire to preserve traditions

This study found that some of the women showed both love for, and trust in, their traditions and culture, and saw them as necessary to follow. Women living in the camp replicated their lifestyle in Syria, including maintaining the home structure, cultural setup and dynamics. This results in a similar environment to that found in the villages in the southern part of Syria, where families live close to each other and the authority of decision-making is based on age and sex.

A clear emphasis on the value of preserving these traditions was made by women who said ’the safe, effective and accepted advice and practices are what they receive from their mothers/elders and from trusting the inherited beliefs’. Also, they expressed how inherited beliefs and traditions ’protect [them]’, and how they have ’a positive impact on family’ and help women to be ‘accepted in the community’.

Service providers highlighted that women became more tied to their culture after being displaced. This was clearly evident through the wearing of traditional clothes, cooking and general behaviour. The consensus was that they are trying to preserve their traditions and identity.
“Women subconsciously do it as if they are trying to deliver a message, this is what is left from her identity; the accent, the way they cook, their food that is what is left from their identity there is nothing to fight with except this”(Midwife)

Many women consider preserving their cultural identity in such a context as more important than their own health and wellbeing because of a combination of deep-rooted beliefs and a feeling that their responsibility in life is to carry out their cultural practices.

“This is the only thing (referring to food, lifestyle, hobbies) that remind us of our land in Syria. We used to have a morning gathering, families live with each other, small towns where we all know each other” (woman, 37 years)

“It is our responsibility to preserve what we inherited and pass to our children” (Woman, 28 years)

The gynecologists and a midwife also observed that many women who visited the health centres were traumatised as a result of what they had experienced in Syria as well as what they were going through in the camp. To carry out the same traditions, speak about their memories and even decorate their houses as they were back in Syria functions to give them a sense of security.

Large family and male preference

Women in the camp follow what is considered acceptable, normal or appropriate by the majority community rule, as they think that these are the right things to do. The preference for having a big family is part of their Syrian tribal tradition and deep-rooted culture and was one of the strongest themes which emerged in this study. Women aged 31-36 years explained the social norms that support having a big family as common-sense, realistic and of

practical strategic interest. Women have a pre-determined belief that their role in the community is to produce a big family, and they feel that women are born to produce children, and that they cannot do anything about it.

We observed from the participants in this study that values held by Syrian women are centered only around serving others. They are raised in their community with the central belief that they should be reproductively active and are accepting of this. The women justify this by explaining 'a woman who has more children has a better status in her community' since more children are described as 'wealth on earth'.

The study found that the level of pressure to bear children seemed to be less among women aged 18-24 years although they stated that they were taught by their elders that the more children they could have, the better they would be for their family.

Having a large number of children is not the only factor that boosts family status among their community; only male children count towards this. According to women, having many sons secures a better financial income and guarantees a social protection system for the family. In addition, male children are the ones who retain the family name and guarantee its continuity.

Women aged 37-42 years highlighted that having many brothers is a must, explaining that they support each other and give more strength and power to a family. Women in this age group also reported that male children are preferred as they can work to support the family financially. They emphasised that many fathers in the camp are jobless, so they count on male children to earn money. Women aged 31-36 and 37-42 years confirmed that this tradition dates back to Syria in the times before crisis when male children were considered as part of the labour force.

Women aged 31-36 years felt that the number of male children in the family does matter. The majority of participants in this age group reported that they were requested to keep trying for male children in order to enhance the status of the family. For example, a 36 year old woman said *"When brothers grow up, they become united, bonded, and stronger to support each other".*

This is what also confirmed by a social worker who said, *"there is preference to have many male children who can stand as one united bond in the tribe community and who can support the family financially."* This sentiment was also expressed by a midwife *"The community expects women to give as many boys as she can. … for them, boys can hold the name of the family and guarantee its extension and continuity".*

Some participants of the focus group discussion, mostly among women aged 31-36 years, mentioned that Syrian families do not count girls when they are asked about their children, as they believe that girls will move to other families after marriage and that only boys can hold the family name and pass it to next generations. Boys are considered the source of power and strength, unlike girls, who are usually considered a source of weakness for the family and sometimes are deemed as a commodity that they have to keep for a certain time. The exception to these sentiments were the participants aged 18-24 years, who stated they have no preference for having boys or girls and they did not feel pressured to give birth to boys.

Some participants linked the desire for a large family size to the high prevalence of child marriage in the camp, and talked about how marriage at an early age leads to a big family, presumably under the assumption that young women have many years of fertility ahead of them to give birth to many children.

Other practices shaped by culture

Tribal tradition does not only require big families, but also shapes many aspects of people's everyday lives. Most participants in the focus groups confirmed that culture dominates their lifestyle and influences their decision on whether to utilise family planning services.

Most of the women aged 18-30 and 37-42 years, reported that traditions prohibited women from learning about reproductive health or family planning before marriage as this was not accepted and was seen as 'a shame'. Women aged 18-24 years pointed out that elderly women used nicknames for contraceptives to mislead and distract young women from understanding what they were talking about and asked young women to leave if they wanted to discuss something related to reproductive health.

"I learned about reproductive health after I got pregnant, I was extremely shy to ask my mother about these things"(Woman, 28 years)

Participants stated that accessing reproductive services before the first pregnancy or visiting the centre without someone to accompany them were both culturally unacceptable. Women aged 24-30 years confirmed that to go to the clinic they have to find an escort and plan for it ahead of time as they must be granted permission by their family. Participants of three focus groups confirmed that unmarried women can only visit the centre if they have health issues. Some women, mostly aged 37-42 years said that according to their culture and tradition, they cannot question the desire of their family, with isolation from the family and community being a possible consequence.

During focus group discussions, women, mostly aged 43-49 years indicated that tradition forbade any examination by male doctors back in Syria. When they first arrived in the camp there were very few female health professionals in the clinic, and they found it bizarre to learn that a woman can visit a male doctor for medical treatment. This was also acknowledged by health professionals and social workers who reported that norms and traditions surrounding the gender of the medical providers play a major role in the underutilisation of family planning services.

This was expressed by a humanitarian stakeholder; *"Women should not attend a health service or come to the centre alone; she should be accompanied by her sister or her mother-in-law. Some women do not accept to be examined by male doctors; they need female doctors and nurses, which we totally respect".* A gynecologist explained that women's movement in the camp is restricted. Women must obtain permission to visit the clinic, and also must be accompanied by an older woman. Usually, women visit the health workers who they and their families are already familiar with.

4.1.2. Community expectations and pressure

A recurrent theme was the desire of women to either gain social approval or avoid social sanctions. Some women described a deep feeling of disappointment and powerlessness when considering the barriers to going against the norms; even though women may have the knowledge and will, they do not have the right to practice what they desire. Some other women stated that adherence to the inherited beliefs and traditions, at least to some extent, may be due to a wish to avoid the negative consequences of not doing so, such as being gossiped about. Women care about how the community perceives and treats them and may behave against their beliefs or self-interest in order to comply with expectations.

All women other than those aged 43-49 years mentioned 'community pressure' and 'expectation' as drivers of culture and traditions. This impacts on utilisation of family planning methods and the size of the family. Women aged 31-36 years reported that women compete with each other in the camp over having more children. The more children a woman has the better status she has in her community. This is all the more true in a close community like Zaatari, where women constantly compare themselves with each other. A woman giving birth to a boy or having a large family results in pressure being felt by other women to do the same to maintain their status in the community.

Most women in the 25-30, 31-36 and 37-42 year age groups confirmed that community pressure regarding childbirth came from everyone surrounding them, both young and old, inside and outside the family and that the pressure started from the first day of their marriage. The majority of participants stated that they were influenced by their friends and neighbours to have children in rapid succession without spacing. Upon probing, they clarified that they were forced by their husbands, elder women and extended family to have more children on top of additional pressure from the surrounding community. Most women also commented that there was social pressure to be constantly pregnant, presuming that this was their primary role and purpose in life. This subject is non-negotiable, as some women believe that it their role, and others stated clearly that they cannot question it.

"She has to prove that she can have kids, you know it is a must for her people to see that" (Woman, 24 years)

A humanitarian stakeholder stated that women are the last to be consulted when it comes to family related matters, and cannot discuss, express or negotiate when they get pregnant or the number of children they would like to have. From their side, a gynecologist confirmed, *"on many occasions we witnessed the mother-in-law decide reproductive health issues on behalf of the woman herself, even without asking permission."* The social worker concurred that *"women don't know or they cannot express their opinion due to many reasons, such as fear of the reaction from their surroundings, they also don't know how to negotiate and many others think that this is how it is and they go with the flow".*

Women aged 25-30, 31-36 and 37-42 years summarised the situation as everyone expecting the newly married women to immediately have children, constantly asking 'why isn't she pregnant yet' or 'when she will bring another brother or sister to her current children'. This pressure results in women becoming concerned if they are not pregnant within 6 – 9 months

of being married, causing thoughts of 'why am I not having a baby', 'people will start talking about me' or 'I should go to doctor'.

Health professionals and social workers reported that they have observed the expectations put on women during clinic visits and outreach activities, and how this pressure flows from the community, mothers-in-law and husbands.

"It ended up that everyone is forcing women to do what the community expects. I will not say it is a physical pressure, it can be a verbal pressure or family social pressure too. There is strong social pressure in the camp to have a polygamy and for women to produce more babies"(Midwife)

If a woman does not get pregnant immediately after marriage, people in the community will question her ability to give birth and she will be in a defensive position, powerless to share her wish or plan. Parents-in-law will ask her to go to a doctor to check on her fertility or they will return her back to her family to be given treatment. Therefore, most women try to be pregnant all the time just to show that they are fertile and to stop gossip and protect their status.

"People want us to keep pregnant; they want us to do nothing but deliver and raise children" (Woman, 28 years)

"We do not have any other option and we are unable to share our thoughts; this is the norm. I want to produce all the children one after the other, to be able to enjoy my life" (A woman, 25 years). She was not in agreement with having many children, but in her perspective fulfilment of community expectation is necessary, regardless of her wish.

"We are under pressure from everyone surrounding us; in one way this is what we are for. We cannot question this fact. We accomplish our duty towards our family and then we have freedom to move" (Woman, 31 years). She was in agreement with having many children, but at the same time she stated clearly that she has no power to think, negotiate or confront the norm, and was referring to it a challenge.

"During gatherings, if you don't have children yet, everyone starts staring at you, as if you are incomplete or less than others" (Woman, 31 years)

Women aged 18-24 years pointed out that if women do not get pregnant immediately after marriage, elder women in the family push them to go for traditional Arab medicine, stemming from a belief that it works faster, and it is the safest treatment. Women aged 25-30 years highlighted that a husband's relatives will give women three years after marriage to give birth, otherwise the man has the right to divorce her and marry another woman.

These findings show that women get subjected to negative consequences as a result of violating or not following the shared norm. According to many participants, gossip and ostracism from one's family or community may start if a person is perceived to have acted in a socially unacceptable way or against the community's norms (for a person of their gender, age and position). It was also apparent from the analysis of the focus group discussions that this can refer to a failure to act in a time appropriate manner to an expectation of behaviour (such as a failure to give birth to many children or boys while still young). Moreover, most of

the women stated that they are not in a position, or do not have the power, to negotiate or question the time and size of their family, referring to many reasons, such as norms, traditions, or religion.

Women aged 31-36 and 37-42 years mentioned that the set-up of the camp and living in one caravan (prefabricated house in the camp) made the issue of having children more complicated as in these tight quarters it becomes everyone's business. Women aged 31-36 years reported that they have a fear of exclusion if they do not adhere to community expectations.

During interviews, health professionals reported that comparison, gossip and the perceptions of others in the community puts women under pressure.

"A woman likes to get children at the beginning of her marriage; so, she can be sure that she can get children and to prove to the community that she can bear children" (Midwife)

"The community looks at the woman who does not give birth, as 'ill' or having some health or social related problems." (Social worker). She also stated that the concept of choice does not exist, and that women follow the norm, living in a defense position unless they fulfill, from their perspective, the duty they are for.

*"Women keep getting pregnant to avoid gossip. The relationship with husbands and extended families were thought to be strained if a woman had no babies" (*Gynaecologist*).* Tension, as a result of not becoming pregnant, between the women and their husbands and family-in-law was also mentioned by some of the FGD participants. This was even justified by some of the women, feeling as though they were to blame, while others acknowledged that becoming pregnant or the gender of their children is not within their control.

Health professionals and social workers reported that some families expect women to have many children to replace those who died in the war. This is one of the least discussed but most impactful arguments that parents-in-law use to pressure women to have more children. Women can feel that this is unquestionable, and the bare minimum they can do for their family-in-law. There is also the perspective that having more children means that the woman will receive more respect from everyone in her social environment.

A humanitarian stakeholder indicated that the community does not look at women as positive contributors in terms of their potential for paid employment, and rather believes that women are there to raise children, cook and take care of household issues. This was also confirmed by health professionals.

"All related responsibilities of raising children are on women only. They consider it purely the role of women not men. This puts an extra burden on women" (Humanitarian stakeholder)

"Some people think that women who use contraceptives are selfish as they do not want to bring sisters and brothers to their children or to have big family"(Midwife)

At the same time social workers commented that there has been a change in the camp regarding the perception of family planning. Some women now consider it 'prestigious' to have fewer kids. The women who have fewer children feel prouder about themselves as they

spaced their pregnancies, which is considered among their peers as an indication of their high level of awareness about family planning and reproductive health.

Social workers also reported that women who have only daughters are disrespected in the community. Many people in the community believe that the daughters of women who give birth to only girls will also only be able to have female children in the future. This diminishes the status of the family and threatens the ability of these daughters to marry later on.

"The women who have only daughters feel excluded and unwelcomed. They are labeled, and people look at them with sympathy" (Social worker)

Inherited beliefs and behaviours

Women highlighted that replicating the practices of elder women, learning from personal experiences and following common beliefs shaped their behaviour regarding the use of family planning. Almost all women mentioned 'inheritance' as a core driver for the underutilisation of family planning services.
The majority of statements made by participants about the use of family planning were negative in tone and suggestive of harm coming from using various family planning methods. The judgments were mostly based on beliefs they had inherited from elders, which came mostly from the elder's own personal experience and were accepted without question as being valid. Health professionals and social workers confirmed that from their perspective, inherited beliefs and behaviours had negatively affected the utilisation of family planning services.

Personal experience

Additionally, negative comments from Syrian refugee women towards some family planning methods emerged from personal experience, particularly of using intrauterine devices (IUDs) and oral/injectable contraceptives. The perspectives were generated from bad individual experiences that women had gone through, or heard about second hand, both of which hindered them from using family planning methods or drove them back to their common traditional practice.

Participants expressed their personal experiences by using statements such as 'lost health', 'got severe pain with (IUD)', 'tried it (IUD) but did not like it', 'it (Injection) affects future [?] fertility', 'not comfortable with (pills)', it makes us feel nervous', and 'gaining weight after using (pills)'. The majority of female participants aged 18-30 years used natural methods while women aged 37-42 years preferred IUDs and pills.

"I was in constant severe pain after I placed IUD, I *was shouting at everyone around me… no one knew why but I heard them talking among themselves that I may be mad. I regretted I did not listen to my mother's words (referring to the advice she received to not use family planning method)" (Woman, 23 years)*

Different age groups also had varying reasons for negative perceptions of family planning. Older women were more likely to describe what they had themselves experienced while the majority of younger women's opinions were based on what they had heard from their elders.

According to many women, it was a lack of knowledge about modern family planning methods that forced women to search for alternative solutions, often older practices. Therefore, according to them the decision when and how to use family planning methods was mostly driven by the norms, traditions and culture of the Syrian community.

All women aged 18-24 years strongly recommended the use of a traditional birth control method that their grandmothers had used for many years back in Syria called 'Hab al Aziz', or the ground seeds of a herb/bush, that women take a spoonful of orally every day. They described this as the best and safest method to delay pregnancy, given that it is organic and extracted from seeds. They recommended the use of Hab al Aziz because they had 'a trust of elder women's previous experience', 'everyone used it' and 'there is evidence of its effectiveness and safety.'

Most study participants highlighted the effect of bad personal experiences on the decisions of women and people around them. Women often share their personal experiences of family planning and advise each other on what to use. Health professionals and social workers acknowledged that information is spread quickly by word of mouth in the camp context, where a small tribal community lives in a closed setting and women easily influence each other. Most women commented that advice from an experienced woman is better than the advice of a doctor.

"In a conservative close community like Zaatari camp, personal experience plays a major role in the underutilisation of family planning, especially because a woman's story may easily become the topic of discussion during social gatherings"(Social worker)

"Women receive information about services and feedback from other women who have either previous experience in family planning services or who have learnt from other women about it"(Social worker)

*"If you want to change a behavior, let a group of people try something and feel the difference, they will promote the behaviour later to a larger group"(*Gynaecologist*)*

Humanitarian stakeholders questioned the quality of knowledge women received in clinics and awareness sessions, in terms of its cultural sensitivity and whether it is applicable to women's daily life routines. Moreover, its comprehensiveness in describing the broad range of family planning possibilities and providing supporting facts about each method. It was said this was particularly concerning given that myths about family planning were becoming so prevalent in the community.

"*For quality assurance, it is important to evaluate the way practitioners provide information to women, whether it was through lectures, face-to-face, or outreach activities and examine the time they allocated to explain the methods' benefits and consequences to women" (Humanitarian stakeholder)*

Despite the fact that most of the women shared their negative personal experiences about family planning methods, many of them had a neutral perspective toward the concept of family planning. This was clearly shown as the majority of women who participated in the FGDs used family planning methods, at least for short periods of time in their life.

During the FGDs, many women in the 25-30 and the 37-42 age groups said they were in favour of discussing family planning issues with partners and using family planning methods at an early age. They believed that having many children would negatively affect their health and that the camp is not the best place for children to grow up in, specifically regarding educational opportunities. However, at the same time, many women aged 37-42 years stated that they wanted to discuss family planning with their partners, but for various reasons they were not able to do so. The majority of responses indicated that women feared being excluded from the decision-making progress if they discussed family planning. This aligns with the statements demonstrating that many women were committed to preserving their family's values and traditions, highlighting the harm that would result if they did not follow the community norms or did not fulfill family expectations.

"It is a predetermined inevitability, women's beliefs, whether positive or negative, do not affect the final decision of using or not using family planning… women should follow the norms"(Woman, 44 years)

Women aged 31-36 and 37-42 years tended to believe in the traditional role of the wife, meaning that the family had a stronger role in deciding if, when and how many children to have. Statements that verified this belief included 'this is what women are for', 'women do not have a hand in it' and 'women lack freedom of choice', and that 'they have to give birth to satisfy their husbands and families'. They were reluctant to use family planning methods due to 'fear of husband's reaction', 'negative influence of mother-in-law and community,' 'gossips', and concern that they would 'lose protection and support'.

Some women believed that the family planning practices recommended by mothers-in-law and elders in the community were more safe, acceptable and beneficial, therefore they had to follow the inherited beliefs and behaviours, norms and traditions of the community. For example, almost all women who participated in the FGDs believed that women should not use family planning methods before the first delivery and that they should give birth to children without spacing in order to have a large family and satisfy their husband. Women pointed out that, as per Syrian customs and beliefs, a 30 year old woman is considered old, and by that age she should already have many children and grandchildren, and according to their beliefs, only women aged over 40 years could use family planning methods.

Many women who participated in the study, mostly aged 18-24 and 25-30 years, believed that by having many children, they would have more freedom to move and take care of themselves later on. This comes from a belief that when children are grown up, siblings take care of each other and the mother's responsibility by then will be accomplished.

Only women aged 25-30 and 31-36 years referred to the misconceptions about contraceptives they had inherited from their mothers-in-law and neighbours in the community (e.g., 'IUD blocks us', 'it caused infertility' and 'health condition deteriorated after using methods') and how they had to follow advice to not use family planning services to avoid harm, although it was against their personal wishes.

During interviews, a gynaecologist, a midwife and social workers also confirmed that many Syrian women in the camp believe that IUDs cause discomfort during sexual intercourse.

Elaborating on this, they said IUDs harm men or cause pain to both parties, and that if the IUD were to be kept inside for too long it would not be possible to take it out.

"The adherence to inherited beliefs and behaviours was mainly a means of avoiding the consequences of using family planning services" (Humanitarian stakeholder)

Health professionals reported that women chose to follow the advice of family members because they believed that this would make their lives easier, and therefore their beliefs and actions were shaped by the surrounding environment. The Health professionals also stated that women believed that making men, parents-in law and their community satisfied is their primary objective in life.

"A woman does not use family planning as she believes that this is how her husband will be satisfied"(Midwife)

*"There is a strong belief that the more a woman gets children the stronger the marriage will be" (*Gynaecologist*)*

A midwife and a social workers observed that women believe in the importance of family planning as they usually come to the clinics for follow-up visits, but usually they stopped using family planning after six months due to a non-supportive environment and being always under pressure from partners and their families to revert to traditional roles and they do not have power to negotiate or to speak up.

*"It was top one reason of why women did not come to the follow up visits, they are convinced they do not have the ability or freedom to decide or discuss" (*Gynaecologist*)*

4.2: Family dynamics

The majority of causes of the utilisation of family planning were directly or indirectly linked to family interference, which refers to the pressure on women from her close extended family, whether husbands or mothers-in-law.

4.2.1: Family interference

The role of mothers-in-law was a strong theme in all FGDs except among women aged 43-49 years, who were already mothers-in-law. Most women who participated in the focus group discussions claimed that the majority of Syrian mothers-in-law interfere in the personal lives of their sons after marriage, and that mothers-in-law have control and power over their families, including sons, daughters-in-law and grandchildren.

Participants had mixed views about the rights of in-laws to control and interfere in their son's lives; some justified it due to the amount of investment and care they have given to raise their sons, following the tradition and culture in the community, preparing them to hold the name of the family. Some women were more thankful that the level of interference decreased significantly in the camp compared to what it had been in Syria, given that many couples had to live in separate caravans relatively far away from their mothers-in-law.

The way women presented the interference of mothers-in-law varied from one age group to another. For example, women aged 18-24 years explained that they listened to the advice of

their mothers-in-law on 'what to do', 'which contraceptive to use' and 'where to go', presuming that the mothers-in-law have the knowledge and long years of experience from which they can benefit. In addition, most women confirmed that it is part of the Syrian tribal tradition to follow exactly what mothers-in-law prefer and to never argue with them.

Most women aged 25-30, 31-36 and 37-42 years reported that mothers-in-law were the ones who kept insisting and pushing to have a big family and male children. Women aged 25-30 years believed that mothers-in-law were justified to make these demands as they were trying to preserve tradition and culture by having many children. Some women aged 31-36 years exhibited a different and more negative tone when explaining that their mothers-in-law forced their sons to have many children. They reported that their mothers-in-law were expecting them to replicate the experience they had back in Syria, stating in a negative tone that mothers-in-law are 'the big boss', in charge of everything related to their son's life, taking decisions and pushing daughters-in-law to become pregnant. If their orders are not obeyed, they may nag, threaten or abuse their daughters-in-law. Women aged 37-42 years emphasised that mothers-in-law reminded them constantly of children they had lost in the war and pushed them to preserve tradition by having many male children to compensate for the loss and preserve the family's name and status.

"My mother-in-law always tells me, I had got 12 children when I was your age, you should do the same, and you should not leave my son without many children"(Woman, 22 years).

"When we came to the camp, I agreed with my husband to stop having children. After a few months he asked me to have another child. I knew later that his mother pushed for that event though he was not convinced at that time"(Woman, 36 years).

Most of the focus group discussion participants reported that mothers-in-law threatened their sons, that if they did not listen to their words, they would 'get upset with them' or 'not grant them the mother's blessings'. Both concepts hold strong importance in the Syrian community and are linked to religious beliefs and tradition. Most of the women confirmed that a son who does not get his mother's blessing or upsets his mother becomes excluded from the whole community and is considered to not be obeying what God has asked him to do. Women aged 31-36 years pointed out that mothers-in-law use this as a final tool to force their son if they do not listen to or comply with their wishes. In most cases, mothers-in-law were successful in influencing their sons.

Mothers / mothers-in-law

The participants of focus group discussions portrayed the influence of their mothers differently. Women in the 18-24, 25-30 and 31-36 age groups highlighted the support their mothers gave to them over time, including asking them - but not forcing them -to use family planning methods to protect their heath and secure their future and that of their children.

"She contacted me from Syria to make sure that I am not pregnant" (Woman, 37 years)

"She always advises me not to have back to back children as it is not a good for my health, reminding me that I have to care for myself" (Woman, 31 years)

In spite of the encouragement from their mothers to use family planning, some women and social workers pointed out that wives in the camp do not have any other option except following their mother-in-law's decisions. If they do not obey, they do not have any place to go to or access to resources. Women in the camp are not empowered and face losing their social support if they do not conform to norms and tradition. Health professionals showed their concerned about the role of mothers-in-law in advising their daughters-in-law about family planning, suggesting that most of the misconceptions women in the camp had were from them. They also stated concerns related to mothers-in-law putting women under pressure, directly or indirectly and controlling the family.

Women in the camp were said to be unempowered in terms of family decision making, as mothers-in-law control the sons, and the male head-of-household has the main decision-making authority over the wife. Health professionals specified that they only see the mothers-in-law when they bring their daughters to the clinic for treatment, where their role is minimal. Social workers confirmed that the mothers of wives know the consequences of interfering in their daughters' lives against the will of the husband's mother.

"If the mother asks her daughter to do something against the will of the mother-in-law, then the latter will likely ask the daughter-in-law to leave the house and go back to her parents' house"(Social worker)

4.2.2. Spousal communication

Male dominance and male dissatisfaction were mentioned by all professionals interviewed, and by women who participated in the focus group discussions. The influence of men on women was a theme emphasised by most participants and present in all FGDs; the perception of this influence varied between age groups.

The majority of younger women confirmed that communication on family planning issues between spouses does not always exist. For example, most of the women aged 31-36 years said that they had never discussed family planning issues with their husband. Women aged 43-49 years, however, stated that they discussed family planning with their husband without an issue.

Most women reported that the husband is the one who decides whether his wife can utilise or access family planning services or not. If the husband is against family planning, stating 'he is not convinced' or 'not in agreement with', then the wife cannot use these services. This further reinforces the notion that a woman must get permission from her husband and mother-in-law to access services in order to avoid conflict.

The majority of women reported that men usually share their preferences on the number of boys and girls to have, and women will keep giving birth to satisfy their wishes. Women aged 43-49 years were in agreement and accepting of the fact that men have the right to decide

the number and sex of children to have, referring to it as 'he asked for it and I did'. Presumably, men insist on further pregnancies until the desired number of boys has been reached.

Women aged 25-36 years were convinced that the family planning decisions were out of their hands and that they were not able to share their concerns or preferences with their husbands. Women aged 37-43 years were also not completely satisfied with the fact that men control the decisions about family planning, commenting that men do not help women to raise children and that all the responsibility rests on women's shoulders.

"*They come at night asking for children, we have no say… he gets upset if we don't listen*" *(Woman 42 years).*

Women aged 31–36 years were the least empowered among the groups, as they expressed their inability to decide or discuss family planning with their husbands.

"I am not allowed to say what I want or do not want; he did not approve and there is no room for discussion as he is not convinced… I will go with whatever he decides. Unfortunately, they don't understand us" (Woman, 34 years)

Among those aged 18-24 and 25-30 years, the most common statements that emerged from discussion were: 'I cannot take a decision myself'. 'I do not know how to broach the subject', or 'I need permission'.

Even if they believe in family planning, they will use it secretly. *"I put (IUD) without the knowledge of my husband, I cannot tell him, he is against family planning. If he knows, he will send me back to my family*" *(Woman, 36 years)*

Social workers believed that there was little discussion among spouses, and that women follow what the men decide, unable to discuss their will or express their wishes. They are forced to comply, and their surrounding environment is not supportive. This sentiment was echoed by a humanitarian stakeholder *"Male dominance is obvious in the camp, it does exist in all cultures, though I don't know if the camp setting made it stronger".*

Some women aged 18-24 and 43-49 years reported receiving support from their husbands, indicating that the decision to delay pregnancy happened in agreement with their husbands after discussion. Other women said that their husbands were convinced by the benefits of family planning and asked to space births, due to reasons related to the circumstances in the camp and financial challenges. Women aged 31-36 years were the least supported by men, reporting that their husbands do not understand women's views or needs.

At the same time, women who are not asked by their husbands to get pregnant live in fear that they may plan to marry other women or that they will abandon them as wives.

"*My husband supports me to use family planning, but I am afraid he does that as he does not want children from me*" *(Woman, 31 years)*

Women aged 37-42 years associated a man's level of education with their ability to understand the concept of family planning and support women in making a joint decision. However, women aged 25-30 years associated the place where they live with the ability of men to decide, clarifying that if they live in a separate house to their extended family, then men can reach a decision with no interference from others (referring to the mother-in-law).

Health professionals and social workers also observed that husbands decide whether their wives' may access family planning services. They confirmed that they have recognised this situation, and that they have started involving men in the awareness sessions and inviting them to the consultations.

Most women, especially those aged 31-36 and 37-42 years, confirmed that involving men in awareness sessions made a big difference, commenting that women in the camp are aware of the benefits but struggle to convince men. Men's participation in these sessions apparently helped provide information and space for family planning discussions to take place.

'Divorce' and 'multiple wives' were repeatedly mentioned by most women from four of the FDGs as a risk that they can avoid by giving birth often. Both divorce and the threat of additional wives were seen as a consequence of using family planning services as well as a potential outcome of not having enough children, especially boys.

Most participants reported that marriage to multiple wives is very common in the camp. Women aged 31-36 years stated their husbands may marry another woman if they do not give birth to many male children. Most participants reported that husbands put women in constant fear, rendering them unable to discuss their wishes or express their will, explaining that husbands may marry another woman to have more children, sons or even to have a new wife who looks healthier and younger.

Women participants aged 25-30, 31-36 and 37-42 years expressed that they are ready to do anything to prevent their husbands from marrying another woman.

"I want to make him satisfied"(Woman, 28 years)

"I don't mind being beaten every day, but I cannot see him with another woman"(Woman, 34 years)

Most women in the focus group discussions agreed that they were ready to stay pregnant all the time, so that men would not find an excuse for marrying another woman.

"I am ready to bring a baby every year but not to let him marry again" (Woman, 36 years)

"He will find an excuse to marry another woman, whether they are pregnant or not and regardless of the number of children you have. They can find an excuse" (Woman, 39 years)

Health professionals stated that most women who visited the centre were afraid of getting divorced and worried that their husbands may take another wife if they use the family planning services. This fear of divorce and abandonment gives women a very powerful reason to get pregnant often. Social workers highlighted that women aged 43-49 years accepted the fact that if a woman does not give birth, then it is the husband's right to marry another woman. Some also accepted the idea of men having multiple wives.

"*Getting divorced is the most common word that all women raised during the awareness sessions. They mentioned it as a consequence of using family planning methods. They think having many children will stop men from thinking of another wife" (Social worker)*

4.3: Social exclusion

In the camp context, the rights of women and lack of awareness were the main subthemes discussed under the social exclusion category. Many who participated in the study pointed out that life in the camp exposed women to opportunities to learn about their rights, which many were not aware of before. However, at the same time, the context of close quarters, a lack of social networks and a strong cultural and traditional setting contributed to preventing women from realising some rights and using the opportunities and resources, which as a result, hindered them from accessing family planning services.

4.3.1: Camp context

The challenges of living in the camp and how it affected the decision to utilise family planning services were raised by women who participated in the focus group discussions, mainly by women in the 42-49-year age group. Some participants linked it to the women's personal preference while others addressed it as a form of social and community pressure put on women, the latter was stated by some of health professionals and social workers.

Most women who participated in the study reported that the situation in the camp was not appropriate or ideal for women to have many children. Women aged 37-42 years pointed out that the poor living conditions in the camp and lack of privacy restricted women from having a big family. They explained that people interfere with each other's personal lives and women lose control over their children. Thus, they are not able to raise them right, referring to lost tradition and values. This is also agreed upon by social workers, who explained how challenging it is for women to make a decision in the camp context. At the same time women aged 31-36 years reported that the lifestyle in the camp encourages and sometimes forces them to give birth to children one after the other. Women aged 31-36 years highlighted that gossip and rumours spread easily in the camp, which puts a lot of pressure on women. The family's image and the need to protect its status is a sensitive topic which women feel they must maintain. This is also confirmed by gynecologists and midwives who stressed the fact that these concerns are shared by most of the women who visit the clinics.

Instability is another concern raised by many women, primarily those aged 31-36 and 43-49 years. They expressed uncertainty about when they might return to Syria, or whether they would remain in the camp. Women explained that they felt that they were in limbo, not able to decide whether to use family planning methods or get pregnant and have more children

due to the unpredictability of the situation. Some women mentioned that they started taking birth control pills as it is the easiest way to access family planning without a midwife's intervention and that this is more common among women planning to return to Syria. Women aged 37-42 years reported that the uncertainty of not knowing what life might hold stopped them from making plans for tomorrow. From the social workers' perception, concerns surrounding instability and uncertainty raised by the women have a negative impact on the refugees, including on their reproductive health.

Health professionals highlighted that the decision taken regarding which type of family planning methods to use is associated with the length of time they plan to stay in the camp. For women, pills are the safest method as they can stop taking them at any time without the intervention of health professionals. This is also confirmed by social workers, who commented that some family planning methods require women to have follow up appointments with health professionals, and they were uncertain about the availability of stock back in Syria and the qualifications of health professionals there.

"Some of the men in the camp went back to check the situation in Syria, which has led women to start asking to use pills instead of IUD as the first is more available and does not require health professional interventions"(Midwife)

Social workers reported that the refugees are frustrated and cannot tolerate being in the camp with no clarity about their future, leading to many men returning to Syria to check on the situation. They elaborated that the uncertainty and lack of opportunities play a major role in refugees' outlook, shifting their priorities and shaping their decisions. Some women in the FDGs also raised these concerns, saying that there are no educational opportunities or promising paths in the camp for their children when they grow up. Women aged 25-30 years were especially concerned about the future of their children, complaining that the educational services in the camp were poor, and that they felt guilty for having their children live in such a place. The camp was seen by both some of the women and social workers as not the ideal conditions for having or raising children.

Women aged 31-36 years raised the issue of limited financial resources and how raising children is costly in the camp, adding that employment opportunities are very limited, which makes raising many children a challenge. This was mentioned also by a humanitarian stakeholder, who questioned the reason that drives women to stay pregnant all the time, giving the financial challenges the families are living in. Some women aged 25-30 years mentioned that they had stopped using family planning methods as their husbands were working outside the camp and only visited when they had a break, while others said that their husband had returned to Syria. From gynaecologist's and social workers' point of view, they considered the stopping of family planning methods as a temporary condition that women forced to live with, and that this does not represent their wish or will.

A few women linked the setting in the camp with child marriage and couples marrying off their children at early age so as to get more space in the caravan and to have more children

of their own. Some women mentioned that men are looking for young women in order to have more children, highlighting that the community supports marriage at an early age.

Another factor raised by the social workers was that of space and privacy, which was said to be the main topic of discussion during most of the outreach activities and that most of the women were suffering as extended families had to live together in one small place. This also affects their freedom to decide or plan for their own family or their future. At the same time, social workers and a midwife concurred the consequences of child marriage, as phenomena that trigger and influence the decision of couples and a solution from community perception to have a large family. That daughters will marry and move out of the family home early.

4.3.2: Women's rights

Women's rights were referred to by participants of focus group discussions both indirectly and directly while talking about the opportunities women have in the camp and their ability to express their will and decide the number of children to have and when to get pregnant.

"*We do not have a vision of our future. We do not discuss future goals with our spouses. We are not used to doing that, , and no one expects* that from us"*(Woman, 36 years*

*"Women get pregnant after 40 days of giving birth to a child, it is a must. She does not have a say, she has to comply with orders without questioning"(*Woman, 30 years*)*

Some women aged 43-49 years confirmed that they had never decided the number of children to have or what type of contraception to use, explaining that God decides the number of children, while for decisions about which type of contraception to use, they have followed the trends and norms in the community at that time.

Some of the women aged 37-42 years stated that they used to trust their mothers and mothers-in-law blindly without verifying the information, but now they have started negotiating and expressing their views and desires of the number of children to have and when. Health professionals and social workers reported that women have become more aware of health and life related issues, they had become empowered, stronger and more exposed to information compared since arriving Zaatari camp. They also highlighted that women outside the camp are more empowered than those inside the camp, as they can find jobs and take care of themselves and children.

*"Syrian women always say in gathering that they never imagined themselves as having an opportunity to be productive in their community, like they do now in the camp"(*Social workers*)*

Other women aged 25-30 years linked underutilisation of family planning services to the lack of educational opportunities – explaining that young women cannot continue their education, compete with other applicants from outside the camp or bear the cost of education (which is

not free at postgraduate levels). Therefore, the only option available for them is to get married and have children as per the community norms and culture.

"*We cannot continue our education, the only thing we can do is to get pregnant and get busy with children*"*(Woman, 24 years)*

Social workers highlighted that according to Syrian tradition, women who get married must leave their education and focus on marriage and their new life. In the past, continuing education for married women was shameful and rejected by the community, but now the situation has changed towards acceptance. However, there are no educational opportunities for fulfilling this. This is confirmed by health professionals who reported that even educated women in the camp do not have many options and opportunities to fill their time with, except in a very few rare cases.

Some of the women aged 37-42 years highlighted that the opportunities they received in the camp were significant and that they now feel stronger and more empowered. They have the opportunity to work, move out of the house and walk in the street, which were not common practices in Syria. At the same time, some women aged 31-36 years found that the employment opportunities and activities for educated women are very limited in the camp, which makes them feel powerless.

"Work options are limited in the camp, the most that women can do is to become a teacher, and if this this is in case, she would already have got her education from Syria"(Woman, 31 years).

Social workers commented that in the camp most women are dependent on their husbands and parents-in-law. Some women reported that they had been living in constant fear, explaining that when they did not get pregnant immediately after marriage, and did not have boys, they had been subjected to emotional and physical violence by their husbands and mothers-in-law.

"it was a nightmare; I went through a very difficult situation and I was stressed almost all the time. But thanks to God now I am grateful for having my son with me" (Woman, 27 years)

*"He shouted at me every time, saying why do you bring me girls only, I want a boy" (*Woman, 32 years*)*

*"I wanted girls, but my husband and mother-in-law wanted boys. I am lucky I gave birth to a male child first, otherwise; I would be under pressure to get pregnant again and again until I have a boy" (*Woman, 18 years*)*

Midwives and social workers discussed the fear they see on women's faces when they learn that they are pregnant with a girl and not a boy. They also talked about the amount of pressure, harassment and violence the mothers-in-law subject them to in the clinics and in front of other women and health professionals.

*"The community and everyone puts the blame on women, if anything happened, she is always on the spot"(*Social worker*)*

Midwives reported most of the women approaching the centres or visiting the clinics are aware of family planning methods; they confirmed that they spend sufficient time with visitors explaining the methods and giving them time to think, discuss and choose the best methods with their husbands. However, most of the women cannot make decisions and are unable to discuss reproductive health issues with their husbands.

"I ask the staff to explain the positive and the negative consequences and the symptoms of using each method, we give women time to choose, and we respect her choice and will" (Gynaecologist)

4.3.3: Lack of knowledge

Some women who participated in the focus group discussions, mostly aged 18-31 years, acknowledged that they had never heard about family planning before leaving Syria, primarily due to cultural sensitivity and lack of available services. Most women confirmed that they were reluctant and shy to talk about their reproductive health and delivery related topics, likely due to health illiteracy, culturally related barriers and lack of knowledge of how to discuss such topics.

Women aged 18-24 years confirmed that sex education had never been a topic of discussion and that they were always excluded from any discussion related to reproductive health. Most women stated that they started learning about reproductive health slowly after marriage from friends and people around, but not from a reliable source while others reported that they knew about family planning methods only after their first pregnancy. Most of the women in the 37-42-year age group stated that doctors in Syria had never explained the consequences of family planning methods.

The majority of women showed their satisfaction and appreciation with the amount of information they received in the camp about the family planning services, especially those aged from 43-49 years. Participants aged 37-42 years explained that they received information about family planning methods from the awareness sessions they attended, the social workers who had visited them and the nurses/midwives in the health facilities. They reported that young women in the camp have become more aware and knowledgeable of reproductive health issues than the older women.

*"Yes, we lost our county, we experienced a very tough time during the crisis to reach Zaatari, however the amount of new information we received in the camp was enormous" (*Woman, 38 years*)*

*"They collect women from the street to tell them about family planning" (*Woman, 44 years*)*

"Through the visits the women center or the clinics, midwives told us about family planning methods in the waiting room"(Woman, 19 years)

Some of the women commented that nurses and midwives in the camp approached them with information on family planning immediately after delivery though they clarified that they were in pain and not in the mood to listen to advice or have another baby. They commented that the desire for having a new baby comes usually around 40 days after delivery and that it is important for midwives to know the best time to deliver the messages.

"When I delivered my baby, they told me about family planning"(Woman, 25 years)

Social workers commented that unlike the situation in Syria, young women attended awareness sessions and participated in the community programmes on reproductive health. Young women grow up and live now in a relatively supportive environment unlike older women (grandmothers) who up until now had deep rooted ideas bound by tradition. In this regard, health professionals reported that awareness sessions alone were not enough to solve the problems in the camp where myths are strongly rooted in the women's beliefs.

"I am not sure if the awareness session was sufficient and was the best approach to reach women" (Humanitarian stakeholder)

Health professionals and social workers observed that low literacy and poor sex education played a major role in the underutilisation of family planning services in the camp. Humanitarian stakeholders and gynaecologists reported that the data with regard to number of visits to the health centre and amount and types of contraceptives used did not reflect reality. A humanitarian stakeholder reported that at the beginning of the crisis, there was a huge consumption of condoms in the camp, but the real reason was that children filled them with water and used them as balloons.

Gynaecologists and midwives reported that women's ability to convey information to their husbands was questioned, explaining that women receive condoms from the clinic, but men are the ones who have to use them. Men received information from the wives without proper training on how to use condoms and most men do not approach the clinic to learn how, according to social workers. This may be due to the fact that most health providers are women, and the unwillingness of men to approach women to speak about condom use was a huge challenge according to health professionals.

From her point of view, a woman, 34 years, raised a concern that "*it is impossible for men to go to clinic to ask a female health worker about family planning methods. They ask us to do it. They feel embarrassed*".

Social workers stressed the importance of involving men in the awareness sessions. Gynaecologists and midwives believed that women could use contraceptive methods if their husbands are convinced and emphasised that the role of husbands is very important and if the men are against family planning then their wives will suffer.

"I think we have to work harder on raising the awareness among husbands" (Humanitarian stakeholder)

Humanitarian stakeholders and a gynaecologist reported that most health providers in the camp came from areas surrounding Zaatari camp and from the north of Jordan where many

Syrians lived even before the crisis. These workers commented that most women in the camp have low levels of education and can barely read although the camp has an accessible educational facility. Health providers therefore interacted with the Syrian community using their own language and ensuring the information was simplified to be appropriate for the level of understanding and education of the women.

Providers reported that at the beginning of the crisis, organising and enticing women to attend awareness sessions was a challenge. Initially, health professionals had to wait for women who were interested in attending the sessions though later on, based on feedback and observation, health professionals started being more proactive and reached out to women in their community. A health professional commented that there were many missed opportunities that they were not aware of, especially among women who were restricted in their movement and who lived in an unsupportive environment.

"We should evaluate the effectiveness of awareness sessions and mentor the way the information is communicated, and the programme is implemented"(Humanitarian stakeholder)

4.4: Availability of family planning services

The availability, accessibility and quality of family planning services were described as major drivers for their utilisation. Participants explained the development of these services over the years since the time of their arrival in Jordan till the present day and compared it to the situation back in Syria.

4.4.1: In Syria

According to some of the women, not all family planning services were available in the southern part of Syria, where the majority of women in the camp who sought refuge are from. Services such as contraceptive pills and condoms were available, though women who opted for IUDs had to visit a private health practitioner and pay for the service.

Women aged 31-36 years reported that unmarried women are unable to access family planning services due to this being culturally unacceptable. Women aged 37-42 years confirmed that women under the age of 30 were not allowed to use IUDs, while women aged 43-49 years reported that it was forbidden for women in Syria to take injections before the age of 40, adding that doctors would not insert an IUD for a woman if she did not have at least four children. Most women in the youngest age group (18-24 years) confirmed that doctors in Syria refused to give contraception unless for a serious health issue.

Regarding having access to information, most women stated that health professionals in Syria did not explain the details and consequences of family planning methods or give women the opportunity to choose the method that suited them best.

"Here in Jordan people like family planning and they do not want Syrian women to get many children… but back in Syria, a woman can get pregnant twice a year, we never cared about family planning or spacing between births"(Woman, 43 years)

Moreover, most women confirmed that there were no reproductive health awareness sessions and that they used to receive this type of information from elder women or traditional midwives.

"If you want to know something about reproductive health, you only need to sit with your neighbor, mum or sisters and they would tell you this and that. This is how we learnt about pregnancy and family planning"(Woman, 44 years)

Women had varied views on the availability of services in Syria, which were not related to economic class, background or geographical location, as they all used to live in the same villages. Some found the services in the camp similar to what was available in Syria, while others thought that services in the camp were far advanced. It was reported that there was a wide selection of public and private health facilities in Syria, and women were able to access the facility which best suited their needs.

"I found the same services I used to have in Syria. I could not see any difference. Just dealing with different people who I did not know before" (Woman, 39 years)

Women aged 18-24 years and 43-49 years confirmed that the norm was that women visited the same doctors and hospitals regardless of where the facility allocated them.

"*we all know each other in the village, majority of health professional were from the community itself and they are familiar with the history of each family" (Social worker)*

"[the same] *health professional provided services to our grandmothers, mothers and granddaughters during their pregnancies*" *(Women, 37 years),* referring to the fact they had long years of experience and the knowledge of health history of the families.

Other women said that health facilities were not accessible as they were unfamiliar with the concept of visiting the hospital or clinic during the pregnancy. Women aged 31-36 years stated that Syrian women in general go to hospital when they first get pregnant and then after 7 and 8 months of pregnancy and that family planning was not a common service to request.

"We used to live in some remote areas in Syria, where health services were not easily accessible to women, hence our visit to clinic was limited to confirm our pregnancy and to deliver" (Woman 40)

Regarding the quality of services, women aged 25-30 and 31-36 years complained about the treatment received from health professionals back in Syria and how they did not give them time nor proper consultations during their visits.

"When I delivered my baby in Syria, the midwife kicked me harshly on my leg. I felt so bad at that time. I could not forgive her" (Woman, 24 years)

"There were no examinations, consultations or pre-and post-natal care visits, we only learnt about it when we came to the camp"(Woman, 35 years)

"In Syria the staff do not discuss or explain the methods and its sequences. Here is much better as they explain all the methods, inform the visitors about the consequences and give the

choice for the couple to decide … this is in addition to the awareness session and men's involvement in related activities"(Social worker)

4.4.2: In Zaatari camp: Many of the women arrived in the camp not long after it was initially set up in 2012.

Women in the 31-36, 37-42 and 43-49 year age groups reported that they faced many challenges accessing health services when they first arrived at the camp, such as a lack of organisation, overcrowding and health professionals who were unable to manage the situation due to staff shortages and not having previously worked in emergency situations. Most women stated that they had to spend the whole day waiting to meet the health professionals for just a few minutes. Moreover, they pointed out that there was no transportation in the camp, so in some cases it took them an hour's walk to reach the nearest centre. Other issues included there being no outreach programme available and fewer female health professionals than male.

"I used to go to the centre at 6 a.m. to book for an appointment. To get a few minutes consultation from a midwife, I had to spend the whole day waiting in the centre" (woman, 34 years)

Some humanitarian stakeholders reported that the services at the beginning of the crisis were designed as a temporary means of meeting basic lifesaving needs. Family planning services were not available at the onset of the crisis as provision was not a priority and was not part of the Minimum Initial Service Package, which according to the United Nations Population Fund is a series of crucial actions required to respond to life-threatening reproductive health needs.

"We were providing health care to pregnant women only, which are the most vulnerable group in times of crises. We focused on providing safe deliveries and provided urgent care for pregnancy complications. We were not working on raising awareness at that time" (Humanitarian stakeholder)

*"At the beginning of the crisis, the number of services provided were limited as there was no attention to family planning as a priority in the response, and women used to walk a long way to receive the services"(*Humanitarian stakeholder)

Social workers reported that they had only been engaging women who both visited the centers and were interested in family planning which was very few at first. Some women reported that there were few health staff, and that the majority were male doctors.

Gynaecologists and a humanitarian stakeholder confirmed that initially most doctors who specialised in reproductive health were male due to a shortage of female staff, and that according to Ministry of Health guidelines, IUDs should be inserted by a qualified doctor, not a midwife. Sometimes the qualified doctor on duty is male, and this decreases the uptake of IUDs compared to if a female doctor were available.

Gynaecologists and midwives reported that women came to the camp with a mindset that they should be able to obtain services directly without any consultations, and that they were

not used to carrying identification cards or other documents or waiting in a queue to receive services.

4.4.3: Zaatari camp after seven years of the camp establishment

Almost all women showed a high level of satisfaction with the services at the time of the study, in 2018-2019, provided in the camp. Most women acknowledged the accessibility, availability, level of communication and the support they received from health professionals in the clinics, and some women expressed that 'staff are very good', 'tolerant', 'kind and patient', 'supportive', 'helpful', 'caring', 'encouraging' and 'available 24/7'. Women recognised that there had been a huge improvement in services compared to the time when they arrived in the camp.

Health professionals in the camp reported that international agencies had improved the family planning programme based on the feedback they had received from women and after realising that the crisis would take longer to resolve than first anticipated. They highlighted that humanitarian agencies established reproductive health centres in the camp in different locations, a management and coordination mechanism following the Ministry of Health procedures and policies was established and clinics were equipped with assets and followed international standards.

Humanitarian stakeholders confirmed that coordination among health facilities is well-established and that there is a reproductive taskforce to coordinate the provision of services in the camp. The task force is active and consists of members from all international and national health agencies in the camp.

Most of the women discussed the level of coordination between health clinics and the positive effect it had on their lives. They confirmed that every woman has a health card that they can use to access any clinic in the camp free of charge. This card tracking service means the women can use different health clinics, giving women the flexibility to choose the nearest and most convenient clinic.

*"There is a center in every zone to make it easy for us so that we do not need to go for long distances" (*Woman, 27 years*).* This is also what was stated by a humanitarian stakeholder, *"now you can find fully equipped centres operating a full capacity serving different sectors in the camp. Moreover, there is a clinic for almost every two districts".*

Social workers reported that in some cases of psychological abuse, or when some beneficiaries stopped coming to the centre for a long time, they use a coordination mechanism with other organisations to study the case and identify the reasons behind it. This sometimes extends to field visits and home visits to resolve the issues.

*"In a small community such as in the camp, one potential negative outcome may affect the decision of the woman and whoever is surrounding her forever, thus, the role of health professionals in coordination is crucial" (*Social worker*)*

Midwives and gynaecologists reported that there is a complaints box in the waiting area outside the clinics for women to share their concerns and feedback. The clinic manager is also

available to listen to the clients and address any problems and women can also communicate directly with any member of staff if they have any questions or suggestions.

A humanitarian stakeholder gave an example*: "To reduce overcrowding, we separated family planning from other services in the centers and started receiving men, which was not allowed earlier and had been one of our main challenges".*

Some women highlighted the effectiveness of the follow up services in the clinic and explained how these services helped them to continue utilising family planning services. Other women acknowledged the importance of the availability of female health professionals and community health volunteers, and described their role in increasing demand and following up on attendance.

At the same time, it was found by some women that methods, such as IUD and pills, were not always available and often many times the centres were out of stock. In these situations, health providers tried to provide them with alternatives, but women preferred to wait and continue using the method they were comfortable with.

Women aged 18-24 and 25-30 years reported that reproductive health centres are accessible when there is a means of transportation, such as buses and cars. Some women found it difficult to carry their young children to the clinic or to push the baby stroller across the market as it is very crowded and not paved (no asphalt roads or paths for pedestrians).

*"it is very far from my house and I can't carry them or leave them home alone"(*Woman, 23 years*)*

Some women said that they did not mind walking to access further away reproductive health clinics in order to get a better quality of service. Other women pointed out that they preferred to continue seeing the same health professional and would not mind waiting or rebooking if their preferred health worker was on leave. The frequency of clinic visits necessary for different contraceptive methods played a role in their uptake, with some women indicating that they use IUDs to avoid coming to the clinic every month to take the pills or the condoms.

Other women pointed out that it is difficult to live in the camp and attend health centres when you have one child and that having more children allows greater freedom of movement in the camp, as siblings can take care of each other.

*"I don't know where I would leave my children. There is no safe place. I am scared to leave them alone at home, as every time I leave them, I found them in the street after I returned back home" (*Woman, 35 years*)*

*"It is easier to live in the camp, if you have six or seven kids, because siblings take care of each other. I have an eight-year-old daughter, she takes care of her younger siblings when I am out, I count on her, I leave them all to follow up house things, buy groceries, visit women centers or even visit neighbors"(*Woman, 28 years*)*

A woman aged 38, explained that in Syria, life was stable, and families used to live with each other at the same house. Women seldom needed to go out and if they had to, they could

leave children at home safely and it was easy to find someone to accompany them. She compared her life in the camp, saying 'neither my mother nor my mother-in-law with me here with me, I do not have the support I used to have when you were in Syria. I do not know doctors, nor do I have relatives that I can rely on"(Woman, 38 years)

Health professionals reported that at the beginning of the crisis, the number of beneficiaries was small due to a lack of awareness. Through awareness sessions and individuals and groups counselling, the demand grew for birth control and family planning methods. Health and social workers reported that community health volunteers visited families at home and discussed family planning services with them, advising them to visit the centre and use family planning methods. These outreach activities aimed to reach the women who cannot visit the centres whether for reasons related to restrictions in movement, or health related issues. It was added that there was a mobile clinic (team of nurses) who offered family planning awareness sessions to women prior to marriage.

*"Earlier, there were no outreach services. The focus was mainly on awareness sessions, but now health providers take all opportunities to introduce women to family planning methods, in health clinics, women's centres or even during vaccination campaigns" (*Social worker*).*

Other humanitarian stakeholders reported that international agencies were very keen to follow international compliance and standards whilst implementing the reproductive health services programme although national staff had been given these resources without being introduced to the concept of family planning standards and the rationale behind it. Therefore, the quality of service provision and demand varied from one clinic to another.

Gynaecologists and midwives also commented that the demand for health services varied from one district to another based on the qualification of health professionals, their skills, and their ability to communicate and understand the profile of women.

"The health providers who give more time, listen to visitors and provide a comprehensive package were more accepted by the community, and people were seeking specific workers out and approaching them by name" (Humanitarian stakeholder)

"I don't blame them, there was a high turnover at the beginning of the crisis and many national health professionals *were not introduced to the family planning package nor trained. I don't blame them if they are unable to implement the family planning programme"* (Humanitarian stakeholder)

However, another humanitarian stakeholder commented that *"staff don't take it seriously as there is no follow up or accountability mechanism in place"*

Another humanitarian stakeholder raised the concern that, *"if they don't believe in the importance of understanding the audience profile to deliver information related to family planning, then they will not implement it well"*

As in they responded to the concerns, health professionals reported on the above that according to the international standards, the number of health and social providers in the camp was sufficient to conduct person-to-person consultations and tailor the intervention

according to the individual women's lifestyle and needs, but this was not the case in the camp as service provision was generally reactive rather than proactive.

Many family planning services were being provided in the camp, on average health professionals see 100-120 cases every day, however at the same time, the quality of services provided by health professionals was questioned by their colleagues.

"I am concerned about the tracking mechanism of women who receive the services in term of the uptake of contraceptives and also the number of women who remove the IUD (in and outside camp), it should be monitored to evaluate the interventions"(Humanitarian stakeholder)

In response, a humanitarian stakeholder reported that a supervisory management tool has been introduced in the reproductive health centres targeted at managers, and with the aim of standardising and maintaining the quality of services in terms of equipment, human resources and standard procedures. In addition, they reported that the data management system had been automated, the capacity of centres had been increased, and midwives had been trained and licensed to follow up family planning services and insert IUDs, as well as doctors.

4.4: Summary of findings

The findings detailed in this chapter cover a wide range of factors which were reported as influencing decision-making in the utilisation of family planning services by women in Zaatari camp.

The study found that tradition and culture are ones of the main factors influencing the utilisation of family planning services. Women are held accountable for preserving tradition and maintaining the tribe's status quo of having a large family with predominantly male children. A traditional environment prohibits women from learning about reproductive health or family planning before marriage and in many times, it blocks their access to services. Women care about how the community perceives and treats them and may behave against their beliefs or self-interest in order to comply with the community expectations. Hence, in most of the time women left behind uncappable to question what they are living in and unable to express their wish.

The findings also identified that women preferred to replicate the practices of their mothers-in-law, learning from personal experiences of others in the community and follow the inherited beliefs as they believed that this would make their lives easier and safer. Women in this context are powerless to question the norms of their surroundings and are focused on self-preservation. A recurrent theme in the findings was the strong influence of mothers-in-law and the power they exercised over their sons and daughters-in-law. Most women confirmed that it is part of the Syrian tribal tradition to follow exactly what mothers-in-law prefer and to never challenge this. Hence, some of the women in this situation thinking that this is the right way to live course of action.

On other hand, the challenges of living in the camp was another factor raised in this study that affected ability of the women to enjoy their rights to reproductive health. For example,

instability and a lack of clarity about the future of their children, poor living conditions and a lack of privacy restricted women from having a big family. However, people interfere with each other's personal lives and the emotional and physical violence from their husbands and mothers-in-law can put women in constant fear and under pressure to have a big family. Women are in a weak position for negotiating the timing of getting pregnant and the number of children to have.

The findings also reported that the limited employment and education opportunities and activities for educated women makes them feel powerless and hinders them from discussing reproductive health issues with their husbands or among their community. They are dependent and are deprived from power and possibilities to objectively consider and challenge their role in their community.

The majority of women showed their satisfaction and appreciation with the amount of information they received in the camp about the family planning and the services at the time of the study, several years after the establishment of the camp. However, the quality of service provision and demand varied from one clinic to another and was based on the qualification of health professionals, their skills and ability to communicate and understand the profile of women, their background, needs and challenges they have faced to achieving their wishes. Some women highlighted the effectiveness of the follow-up services in the clinic and explained how these services helped them to continue utilising family planning services. However, the services seem to be limited to scheduling follow-up appointments and the provision of alternative family planning tools to choose.

Chapter 5: Discussion

5.1: Review

The previous chapter presented the findings related to the research question: What are the factors that affect the utilisation of family planning services among Syrian refugee women aged 18-49 years in Zaatari camp, in Jordan It highlighted a recurrent theme that emerged from the FDGs and KIIs: a lack of power and agency among women in the camp was found to be influencing their utilisation of family planning services. The study found that the barriers which impeded the use of such services are deeply rooted in cultural and community norms, with the women in question being unable or unwilling to challenge the structures of power which advocate against the use of such services. Taken together, these findings indicate the need for interventions which encourage empowerment among the women in Zaatari camp and, importantly, interventions which are culturally sensitive.

Interventions must be built around enabling women to feel free and sufficiently informed to decide for themselves whether they utilise family planning services rather than specifically aiming to increase the uptake of these services. This autonomy, as opposed to the women acting in a way that is expected of them by health professionals, is the truest expression of the multifaceted concept of empowerment.

This discussion will examine how to define power and empowerment and explore how empowerment can benefit women and how the camp context can be utilised to provide women with the support to make their own decisions. The benefits and risks of offering economic and educational opportunities, and how these facilitate an enabling environment for empowerment will be discussed. These points will be interlaced with reflections on the linkages between power dynamics and culture, and how careful consideration is necessary when implementing interventions which may contradict the social norms of a community.

The findings of this study will be analysed in the context of the literature and links with existing theories explored. The Dahlgren-Whitehead 'rainbow model' (1991), which maps the relationship between the individual, their environment and health will be used as an overarching framework to build our academic argument. This will focus on the social and community influences in the immediate environment to discuss their relation to individual behaviours and the resulting impact on women's decisions in relation to their health. This analysis will be further built on using Luke's framework (1974, 2005) focusing on the third dimension of power which states that invisible power can transform the powerless individual to act willingly in ways that appear contrary to their most basic interest and as they formerly wished. How the concept of 'negotiated order' can be utilised to enable constructive discussion in the community will be examined (Strauss, 1978).

The role of health professionals is a further element which will be discussed in this chapter. Health practitioners in the camp are ideally placed to provide support to and increase the

knowledge of women, using avenues such as amplifying the voices of volunteers and older women who are knowledgeable about the benefits of family planning.

5.2: Key issues affecting the utilisation of family planning services

The main findings identified multiple key issues which contributed to a lower than expected utilisation of the freely available reproductive health services in Zaatari camp, with the influence of cultural barriers compounded by factors arising in the immediate environment.

On an individual level, this study found that the participants had limited power to think, decide or act autonomously in relation to family planning. These difficulties are further evidenced in the perceived inability or unwillingness to overcome social barriers and take control of decision making. The level of authority wielded by an individual, particularly a woman, is heavily linked to their age, with younger women expected to follow the orders of their elders. Accordingly, the level of perceived empowerment among the participants varied with their age groups.

The study shows clearly that traditionally, it is accepted that the mother-in-law has the right to control their sons' lives, and by extension that of their wives and families. In practical terms, this often translates as the ability to influence their reproductive lives and to prevent couples from using contraceptives through coercion, threats and in some cases, violence. Sons seem to endorse the position held by their mother in the family and community, and are hesitant to object to their wishes even when they themselves might disagree, due to the perception that traditions such as marrying young and immediately having children are rooted in religious teaching. In the interests of avoiding conflict with their families, women were found to prefer withdrawing from the decision-making process. According to the literature (Freedman et al, 2017; Han, 2019) and the findings of this study, violence against women is a prominent issue; Syrian refugee women do their best to comply with orders to avoid such negative consequences. However, this possibly prevents women from understanding the full extent of the choices available and leaves them in the potentially harmful position of unquestioning acceptance of the social order and unaware of how they could benefit from being able to change their situation.

Another major contributor to the lack of empowerment felt among women is the environment of the camp. Their vulnerability is amplified by being displaced and in unsettled and unpredictable surroundings with limited opportunities and agency in decision making. In such contexts, some refugees are likely to become more tied to their traditions (Ruggiu, 2018), while for others, conflict can lead to the loosening of traditional morality especially around sexual activity (Jones, 2008; Francis and Maguire, 2016; Vieten, 2018). In the Syrian context which consists mostly of refugees belonging to conservative tribes, restriction and tradition were observed and documented in some of the studies (Miettunen and Shunnaq, 2020). At the same time, with the political dynamics in the region, there is no feeling of stability as everything could change all of a sudden (Leghtas, 2019). This has led to women in the camp following what is considered acceptable, normal or appropriate by the majority community rule, viewing the idea of having a large family as a realistic aim of practical strategic interest in order to stay protected and respected.

From a cultural perspective, the findings show that women are held accountable for maintaining the status quo and cultural identity of a tribe, and the social obligations and expectations related to this play a major role in shaping their actions and similarly their feeling of empowerment. The fear of losing social support systems and the connection to cultural norms and customs when adjusting to living in the camp has led to a greater effort in exercising values and traditions in order to maintain the connection to their lives in Syria. Indeed, many respondents in this study considered preserving their traditions and identity more important than their personal health and wellbeing in this context.

In the absence of personal empowerment, maintaining their reputation and image in the community is a priority for the women and their families. In such a crowded space, the opinions of others in the community can have a greater impact with the amplified effect of social approval or sanctions when their actions do not align with accepted norms. A low-quality provision of primary education and lack of access to higher education in the camp has led to women not feeling motivated to plan for their future and aspiring only to marry and form a family at a young age. Due to a lack of resources and means to generate income, women lack economic empowerment and the ability to self-sufficiently support their family, often feeling as though they are a financial burden. This dependency deters women from making autonomous decisions due to the potential consequences if their actions lack the approval of their family members. The weak position of some women in the community due to the lack of empowerment resulting from these factors can limit their ability to express their desires or make informed choices about their reproductive lives.

We can conclude that, culturally sensitive family planning counselling services which correspond to the needs of these women are lacking in the camp, leaving women with inadequate resources for reproductive decision making.

5.3: How the findings of this study are similar or different to previously published relevant literature

Looking from the perspective of the individual, most of the previous literature views published in this topic consider the level of awareness of family planning, but none focused on the role of power, and the process of thinking and making decisions, or the inability or unwillingness of women to overcome social barriers relating to their own reproductive health. Other qualitative studies mentioned a lack of awareness about the services and low levels of education among refugees as factors which influence women's' decisions, which was also found in this study, though not mentioned as one of the main factors as other research. Knowledge in relation to sex and age were identified as aspects for further study. In different from other studies, this study acknowledged the level of awareness the young women have in relation to reproductive health, so as middle age women confirmed that the knowledge they received in the camp, they never had before.

All of the published studies retrieved reported that women were influenced by their mothers-in-law, were not able to make their own decisions, and willingly or unwillingly abided by community traditions and restrictions to avoid consequences. This study went deeper to further understand the women's perception of this and how they feel about their lack of

options, finding that that women lacked the experience and confident to question or negotiate personal matters, including around their reproductive health life.

Previous explorations of the women's perspective and their adherence to societal expectations have identified many factors which were reiterated in this study, including maintaining the status quo, avoiding gender-based violence, polygamy, and to make up for those who passed away during the war. This study also investigated the root causes of these factors, and recommended providing an enabling environment for women to negotiate their wishes, allow them to freely question the status quo and find a way forward that meets their needs in the context they are living in.

Syrian women in the camp, according to the literature, have been equipped with opportunities that have enhanced their self-esteem and sense of identity, contributed to empowering them economically, socially and culturally, and have increased their participation in decision making processes. The effect of these opportunities was also evident in this study, as the women who worked in volunteer roles showed more self-confidence compared to others, and volunteers who participated in session more readily shared their thoughts and ideas. Previous studies considered educational opportunities from a variety of angles, though there was no data available on the relationship between education level and family planning uptake for women in the camp. This study considered education as a path that women can follow in order to give them a greater sense of purpose beyond what is expected of them, and something which can enhance their skills to negotiate and discuss reproductive health matters. Regarding economic opportunities, this study agreed with previous work that participating in these is a factor which influences the uptake of reproductive health services, as women feel more self-sufficient and independent, though this study considered dependency from a neutral perspective, with the view that this should not put women at risk of negative consequences.

Finally, when it comes to the provision reproductive health services, all previous studies acknowledged the improvement in the quality of services provided in the camp, and the relationship between uptake and the availability, accessibility and acceptability of services. This study agreed that services had improved, but questioned Additionally, most other published studies discuss the update of services and tools used, but this study focused mainly on the community perception of family planning services, and not the services itself.

5.4: Power dynamics and the influence of culture

5.4.1: Power: Dimensions and dynamics

To understand more about the dynamics of power, Lukes's (2005) tripartite perspective of power explains three dimensions of power which affect an individual's daily life. The first component, "power to", refers to the use of authority to exert direct power in order to overrule the will of a person. This can occur on an individual level though is also expressed through laws and regulations in certain contexts. In Zaatari camp, this is represented by the power that focuses on shaping behaviour by influencing the decision-making process and is related to an issue that is perceived as a conflict of interest. This could be, for example, a woman's decision regarding whether to have a big family or not, which would normally be

considered an unquestionable part of norms and cultural expectations that women should follow. The decision is taken out of women hands. They may be coerced by the holders of power, their husband or their mother-in-law, to either use or avoid the use of family planning services. Lukes's theory suggests that with the development of women's knowledge, self-esteem, confidence and motivation, they may gain more control and drive their own positive decision-making, resisting pressure from peers and family.

Secondly, the "power over" dimension influences how a person can express themselves, and describes a powerful entity who uses an agenda to impose particular behaviours on others, be it on a single individual or group who may or may not be aware of this process. In this case, those in power have devoted energy towards creating social values and institutionalised practices that influence the decisions taken which in turn affect the lives of women. This power enforces social and traditional values, and community practices to the extent that an agenda is imposed on society, while women are prevented from pursuing wishes that contradict the preferences of those in power. Instances where a woman refrains from voicing her opinion on an issue of her interest, anticipating that the other party will respond unpleasantly, she is unwittingly consolidating the dominance of men and mothers-in-law and helping to maintain the status quo of power dynamics.

Thirdly, the "power through" dimension affects the whole entire being of the individual, the formation of their identity and how they understand themselves in relation to society. It encapsulates norms, conventions and social power, and how these elements can directly or indirectly influence the behaviour from an individual level upwards, and shape who people are in their society. This covers the normative and transformative forms of empowerment, which are existent, though possibly invisible, in the community. Luke suggests that this dimension of power is ideological in nature. Through examining this aspect, attention is drawn to the processes of social and cultural reproduction that legitimise the dominant and accepted understanding of the natural order of a certain community. In this study, this would represent the pressure exerted upon women by their husbands and in-laws. Women have been driven into accepted things, which may not objectively be in their best interest, thinking that the accepted course of action in the surroundings is the right thing to do. How women perceive what is in their interests usually differs according to and aligns with the culture and society surrounding them.

The most effective use of power is to prevent conflict from arising in the first place. Women are not capable of affecting the outcome of the first or second dimensions of power if their will is not respected and has been modified based on a normative format that suits a specific agenda. A woman can combat the states of "power to" and "power over" if she is informed about them, but to challenge "power through" would require changing her identity, her place in society and the surrounding world to be able to avoid conflict. This is challenging in Zaatari camp as up until now, many women have not been able to make decisions to support their best interests, for example choosing family size and when to get pregnant, as well as women's priorities, is continually changing due to the dynamic situation, culture and their place within their family and community.

A dilemma exists between seeing family planning as a universal human right which women are being denied by an oppressive set of cultural norms, and seeing family planning as a

culturally specific set of choices that is shaped by norms and traditions. Lakatos (2018) argued that neglecting culture in the implementation of international human rights standards is seen as a form of cultural imperialism, as culture is a fundamental factor in creating common moral values. In some settings, societies justify the unequal treatment of women as being in the name of preserving culture (Lakatos, 2018) and some consider concern for human rights as an interference in their internal affairs (Perean, 2015). Being between the two, the radical universalism versus radical cultural relativism, given that some women feel that they are being denied what they want because of their subordinate position, the researcher acknowledges the importance of supporting these women in negotiating for what they want, and empowering them to make more autonomous decisions by applying cultural sensitivity interventions. At the same time, it is important to not push family planning onto women who have decided that they do not want it.

In the camp, for some women, having fewer children, alongside greater opportunities for education and employment would be the ideal situation but the norms in their community hold up the women who marry at early age and have many children as role models to follow. The dilemma of what women wish and what the community expects is yet to be solved. The fact that some women do not have the right to decide the number of children to have is seen as an issue; some may consider it a personal issue, but it could easily be seen as a wider family issue. Moreover, encouraging a situation where women demand their rights would be perceived negatively by some as the imposition of a westernized worldview, while others would refer to it positively as an emancipatory and modernizing agenda. Either way, women are usually not given the space to think or decide, and for many determining family size is not solely a woman's issue or right.

5.4.2: Contextualising empowerment

This study found that power is one of the main factors that affects the utilisation of family planning services, and that empowerment could be the key to enabling the women in the camp to challenge cultural norms and make informed decisions about their reproductive lives.

In social interventions, it has been observed that those who are deemed less powerful are in fact not deprived of power, but instead possess potential which is yet to be mobilised. This mobilisation can be achieved through reducing vulnerability and promoting decision making and action taking, enabling the person to feel empowered. Therefore, empowerment is not something that can be given to women after which there is an expectation of change, but rather a power gained by the individual, allowing her to explore the potential as relevant to the context and acting upon it if desired.

In the context of this study, is important to look at the concept of power sharing in relationships and communities. "Shared power is defined as a social process that occurs in relationships, enabling empowerment and helping people to gain control over their lives" (Hur, 2006). A wider sense of empowerment in the community would make it a more conducive environment for women to exercise their rights and feel able to express their wishes. In an ideal scenario, the process of empowerment goes from the bottom up, with power gained organically by the people themselves rather than being granted to them by

others (Laverack, 2005; Spencer, 2013). Here is where the real change may happen; however, a transition of this magnitude would likely require time especially as it involves challenging traditions and beliefs.

5.5: Empowerment for family planning

5.5.1: The need for empowerment

When considering the empowerment of women, it is necessary to examine the system which surrounds them and how it affects their autonomy. Lukes's theory asserts that the holders of power within a system will be accepted by the people due to their belief in the system. That power dynamic shapes the preferences and perceptions of the people as well as preventing them from voicing disapproval and challenging the system. He assumes that in such cases, those in the lower tiers of a system will not recognise any alternative to the existing order as they perceive it as natural and unchangeable, or because they value it as beneficial. However, Lukes's theory does not take into account a situation wherein the people do not perceive the power as natural and do not accept it. This context is rather more applicable to that of the camp, where women are not always passive bystanders when it comes to negotiating issues with their family in relation to accessing family planning services.

While some women are not positive about family planning, they do not all accept being dominated by men or women-in-law. Some acknowledge the usefulness of family planning services and others are using these secretly, while the majority neither consider nor accept their existence. However, health professionals seem to be conscious of these attitudes and offer women alternatives to family planning methods. There appears to be a spectrum of empowerment among women in the camp, ranging from women who completely lack the ability or will to negotiate with others, to some who are trying to enter into dialogue with health professionals to help them negotiate with their family to take control over their own experience and place in the social structure. The findings of this study suggest that many of the women in the camp are not freely able to act autonomously in the decision-making process or actively engage in the management of their reproductive health and lifestyles.

Focusing on the issue of autonomy, it is imperative to understand the relationship between all the actors involved in an individual woman's decisions regarding their reproductive health, and the configuration of the social power dynamics. This kind of network is illustrated in the 'negotiated order' theory. According to Strauss (1978), the rules, norms and values that govern specific orders are determined by social orders which are in turn characterised by processes of negotiation between social actors in a certain context. This approach enables the analysis of interdependencies among actors and the negotiations that occur in the social management of health-related issues.

The analysis of this study's findings demonstrates a complex dynamic between the women in question, their families, the wider community and health professionals. Many women are currently in a subordinate position in the process of decision making and are as such incapable of contradicting the forces wielded by those in power. Health norms, in a similar fashion to social norms, are transmitted from older to younger, and women are expected to conform to the social expectations of parents and professionals in the community. If women

are empowered and their autonomy is fostered, then they may have the possibility to negotiate intergenerational and social relationships and alter the accepted social roles.

The roles played by everyone in the community are interdependent and have evolved through a process of negotiation. The perspectives on autonomy held by community members occupying different roles do converge on some points though differ in many aspects. For example, health professionals fail to fully acknowledge the complexity of the situation in which women live and the obstacles that women may experience in following their advice. Despite their awareness of the social context in the camp, they tend to interpret the roles of married males and mothers-in-law through an individualistic perspective. This perspective is also applied to women who face difficulties in following health recommendations although they are required by tradition to bear many children, to manage their often complex lives and to preserve their identity. Meanwhile the family in this perspective represents the role of the protector who has a commitment toward their tribe. In this context the dynamics of power-over and how this has impact on an individual level can be observed.

'Negotiated order' theory suggests that the process of taking decisions in relation to family planning and negotiating within the family could be empowering for many women, as this may open up the possibility of reconstructing their identities and redefining family relationships. Crucially, women who are able to negotiate will be able to enhance their well-being as well as maintaining their status in the community, as they will be more able to reach a middle ground agreement that is satisfactory to each side, an outcome far preferable to the possibility of a community sanction. The power to negotiate has the potential to let women be independently responsible with regard to the management of their reproductive health lives in addition to the other responsibilities they may have.

5.5.2: Barriers to empowerment in the camp context

To better understand how the status of women has evolved into its current form, it is necessary to consider all the structural barriers which stand in the way of empowerment. The social, health and well-being of women is influenced by a range of factors both within and outside the control of an individual. As shown in figure 6, Dahlgren and Whitehead's (1991) 'Policy Rainbow' captures the interplay between these factors by describing the layers of influence on a person's potential for health.

Figure 6: Social Model of Health (Dahlgren and Whitehead, 1991)

Whitehead explains that there are both non-modifiable attributes such as age and sex, and modifiable factors related to the individual's lifestyle, social relationships and community network. This model has been informative in painting a more accurate picture about the extent to which each layer contributes to decision making for women's health, the feasibility of bringing about change through optimising specific elements and the complementary action that is needed to influence factors in the same or different layers. Since the central challenge that women face in Zaatari camp is the restrictive social norms and traditions at the community network level, this community layer as presented in the 'Policy Rainbow' is therefore the entry point of discussions on the linkages between existing structural and individual level factors which impact their lives. The community or collective support may provide an environment which encourages the empowered individuals to take their own decisions; however, conversely, living in an unsupportive environment, as we have seen in Zaatari camp, creates barriers to women being able to express their own will and denies them the opportunity to feel empowered.

One barrier created by the community environment is the threat of conflict. The community environment can influence the fact that women do not challenge norms because of the threat of conflict. Many women who participated in the current study stated that they withdrew from the process of decision-making to avoid being in conflict with their families. Some of them mentioned that they use family planning, to relieve themselves of the pressure to have children but must do so without the knowledge of their mothers-in-law or husbands. This concurs with Marlene and Finlay's statement that going against cultural norms may have a negative effect on women's overall empowerment, and that if family planning is not accepted by tradition, women will not benefit equally from its use (Marlene and Finlay, 2017). The lack of availability of alternatives leaves women in a difficult position as it may change their perspective from being unquestioning of the social order to being critical of it, which could cause more harm than benefit in such a conservative context.

The camp setting creates another barrier as it also affects the outlook of women: maintaining their reputation and image in the community is a priority for them as well as for their families. Women in the camp are living in a close community, where other people's opinions have consequences. The tradition and conservative context in the camp leads to the women caring about how the community perceives and treats them, aiming to gain social approval and avoid social sanctions. Their practices are closely watched, and they are subjected to an array of sanctions for actions which do not align with norms. For example, women who fail to give birth to male children suffer stigma and negative labelling in the community, and women who do not give birth to many children are the subject of gossip and are sometimes ostracised, while women who use family planning are considered selfish. Hence, to avoid gossip and stigmatisation, women are sometimes forced to act against their beliefs or perceived self-interest to comply with the expectations of other members of the community. It is, however, the case that a movement towards a more positive view of women who do not comply with this image was reported by participants and observed by researcher to be developing in the camp.

Women who are independent and have smaller families are beginning to be perceived by the community in a more positive way, and women who earn money seem less controlled by men

and in-laws, evident in their higher self-esteem and more vocal nature. In the camp, it is notable that some women are beginning to consider working and using family planning as a prestigious act that gives them a sense of being modern and Westernised.

With this shift comes the greater need for women to be able to avoid gender-based violence and related barriers that may occur as a result of not fulfilling family expectations. In the Syrian community, women who do not adhere to the orders of their in-laws or husbands are often excluded from the community. If a mother-in-law is unhappy with her daughter-in-law, she might send her back to her parents' home, or pressure her son to use violence against her, or encourage him to marry another woman. Accordingly, the need for women to protect their marriage was one of the most recurrent themes of the findings. Women live in constant fear that their husband might marry another woman, or that they might get divorced or be abandoned. This has also been documented in a quantitative study among Syrian refugees in Lebanon and Afghan refugees in Iran, which revealed that refugee women opt not to use contraceptives and stay close to their husbands due to the fear that they will take a second wife. For these women, having many children is a protection mechanism as polygamy is a culturally accepted practice in Syrian society, especially when a family does not have any male children. (Kabakian-Khasholian, et al., 2017, and Tober, Taghdisi and Jalati, 2006). The norms and social expectations in the camp mean that women tolerate being beaten by their husbands or mothers-in-law in return for a secure marriage and social protection. Hence, women sometimes prefer to stay pregnant all the time, presuming that this is the easiest protective mechanism to avoid barriers, and maintain their marriage and status in the community.

5.5.3: The road to empowerment for Syrian refugee women

After examining the current lack of female empowerment evident in the camp, a road map of how to address this must be developed. Provision of better economic and educational opportunities contribute to facilitating an enabling environment for women to access services. Enabling women to learn skills and earn money would motivate women to plan for their future and equip them with resources to increase their sense of self-sufficiency. A study conducted in urban populations in Nigeria studied the association between women's empowerment and reproductive health outcomes, using baseline household survey data and examining four dimensions of empowerment: economic freedom, attitudes towards domestic violence, partner prohibitions and decision-making. The study showed that the more empowered women are more likely to use modern contraception, deliver in a health facility and have a skilled attendant present at birth (Corroon, et. al, 2014).

Enhancing the quality of education and increasing access to higher education can give girls hope to aim beyond being married at an early age and producing a large number of children. It has been demonstrated in a study conducted among Palestinian women in Israel, that women who have been able to complete their education are more likely to have an opportunity to work or marry at an older age (Sabbah-Karkaby et al., 2017). However, it should be borne in mind that being enrolled in school does not translate to empowerment or awareness of reproductive health issues, but it may delay pregnancy and give them another meaning in life.

The higher the level of education, the greater the positive effect on multiple dimensions of empowerment such as decision-making power and attitude towards social norms (Mainuddin et al., 2015; Miller, 2017). Investing in girls' and women's education will therefore increase their ability to negotiate regarding family planning and give them another perspective on life that they can pursue and explore beyond the circle within which they live. Increasing the level of health literacy would mean that women are more able to discuss, realise or express their rights and desires in their home and in front of their community. This will also lessen the difficulties faced in verifying information, and communicating knowledge to men regarding reproductive health issues. A higher level of knowledge will also increase the women's ability to negotiate based on facts and reach a middle-ground solution that satisfies both herself and her family and community alike.

Empowering women economically may boost their self-sufficiency as they would have control over resources and would be able to generate income and support themselves and their families financially. Being economically empowered also gives women the feeling that they are not a burden to their family and have a level of social standing that allows them to express their desires more freely. The association between equality of employment, women's fertility and reproductive behaviour has been proven to accelerate the pace of fertility decline and to increase the use of reproductive health services (Corroon et. al, 2014).

Being independent would free women from living in fear of losing financial and social support, which sometimes leaves women with limited options and deters them from making autonomous decisions as they may be unable to accept the consequences. Many women in the camp cannot live independently due to cultural barriers, nor can they return to their own parents' house due to the dire economic situation in the camp. Families are hardly able to secure their basic daily needs and cannot afford to support guests in their house, even if the guest is their daughter.

It can be concluded that some women in Zaatari camp have a weak position in their community. They do not have the freedom to make decisions about their reproductive nor their professional lives. Even for informed and experienced women, their increased opportunity to work does not mean that they are informed about family planning and can discuss or influence fertility preferences with their partners. Marlene and Finlay (2017) state that the ability of women to work does not itself signal empowerment, as many women in other contexts are forced to do so. The association between the level of participation in the labour market, women's economic empowerment and fertility preferences should be measured based on the extent of women's decision-making and the ability to make a well-informed decision to have a certain number of children. Some women in the camp see their contribution to helping the family advance economically, in terms of producing many male children who will contribute later to supporting the family financially, as in the camp context they are considered a future labour force. This has been documented in most of the countries affected by the Syrian crisis; it seems to be rooted in cultural and community expectations (UNICEF, 2019; DeJong et al., 2017; Kabakian-Khasholian et al., 2017; ILO, 2015).

The researcher observed that participants who work as volunteers in the camp seem to be believers in and strong advocates for family planning. These paid volunteers, whom some of

the women in the FGDs described as the luckiest, as they had opportunities many other women dreamt of, seemed to have self-confidence and self-esteem and to act independently, feeling important and special among other women in the camp. These women talked in the discussion groups more about prioritisation, birth spacing and improving women's use of reproductive health services and shared examples of how they contribute to making a change. This shows the impact of these empowerment opportunities on the behaviour of women, which is reflected in other studies (Hunt, Samman and Mansour-Ille, 2017; UNWomen, 2018). However, in this study we cannot generalise or confirm the association, as most of these advocates already have more than five children and for them, their obligation towards their family has been achieved. Moreover, we do not know the background of those women and their families. Yet, we may conclude that women who live in a supportive environment that allows them to volunteer, the same supportive environment might also allow them to use family planning.

5.6: The role of service providers in empowering women

In terms of what can be done to improve the current situation within the camp, service providers are key in their position and ability to reach women in need of empowerment. In addition to service provision, health practitioners and social works play health promotion related roles, including empowering the community. This process starts with supporting change for individuals and the community through interventions followed by the translation into mechanisms for sustainable change.

Recognising the personal environment of the women they are seeking to help is fundamental to promoting their empowerment. Service providers as part of their profession acquire an understanding of the relationships between individuals and their environment. They should be mindful of similarities and differences between people from different groups, aware of power, privilege, and oppression (Maschi and Leibowitz, 2018). This is one of the competencies Kirst-Ashman et al. emphasised in their book Empowerment Series: Understanding Generalist Practice (Kirst-Ashman et al., 2018). Understanding the perspectives of women, their beliefs and attitudes will shape the type of interventions designed and types of solutions that are put in place. The aim of service providers is to help develop a set of quality, community-led, and gender-sensitive approaches that are not culturally imperialistic but that are value-neutral to support the community's and women's development in the camp (Carpenter, 2016 and Harrison, 2011). The symbolism of family planning services must also be considered; some see this as an alien concept introduced to them in a new country or as a Western act that does not fit into their traditional outlook. Therefore, service providers must enable women to negotiate the symbolic meaning, angling it more as a form of freedom and emancipation, in order for women to feel reassured about the impact of using these services.

Empowering a woman to take a decision related to her reproductive life is an on-going process that requires time and technique. This is what also urged by Errecson and Bjerge (2019) who said that decisions emerge over time and that many factors influence the negotiation process and time require. In such a bureaucratic organization, like the one in the camp, the service providers need to be familiar with the process of negotiation, the power dynamic and tradition to be able to connect with community, manage situation and perform

their role. The more skillful service providers are, the more they can establish rapport, asking questions, reflecting on hypotheses, and considering how to respond to challenges. Service providers should understand the context, the characteristics of the women, and their daily life routine beyond their apparent psychological or medical state to be able to design a family planning programme that fits their needs and overcomes challenges such as unmet use of services, low follow-up visit levels and access related barriers.

For service providers to be able to facilitate empowerment for others they should themselves be, and feel, empowered, following the logic that undergoing this process themselves will make them more able to apply it to others (Leonardsen, 2011). For service providers to understand their own self-power, the groups they belong to, their relationship with the surrounding environment, the limitation to their power and how to contribute to the fight against oppression will help them better implement interventions. This knowledge can aid service providers in building on what already works, interventions that are culturally sensitive and practical for use in a camp context, building upon those as a foundation for people in the community. Maschi and Leibowitz (2018) emphasised that social workers need to be aware of their own cultural characteristics as well as those of the people they serve, clarifying that without self-awareness, they risk imposing their values and beliefs, and may even become judgmental.

The empowerment service providers are calling for, should not align with their own pre-judgmental preference, culture, values or ethical imperatives. It is important to keep a neutral point of view and dispel the idea that it is difficult to change the mindset and behavior of people who grew up in a culture with a very dominant element. They must also believe that every individual is able to determine how and why they want to live their lives. These are some of the standards for cultural competence that service providers should adhere to when dealing with clients and reflects the fundamental value of the social work profession. They have an ethical responsibility to ensure sensitivity in their practice and demonstrate cultural awareness when working with people from diverse cultures (Carpenter, 2016; Harrison, 2011).

Empowerment utilises the collective, namely collective expertise, participating in collective action and collective action empowering an effective response. It is critical for health professionals and social workers to create safe spaces where women can share their experiences related to family planning and decision making. Sharing those experiences often provides a good foundation of understanding for each individual in the community and minimises resistance, especially if it facilitated by supportive members of the community itself. Supporting empowered women in a close community, such as the camp, could provide role models for less empowered women in the community who are willing to take action but require more support to build up the courage to do so. Collective empowerment contributes to strengthening marginalised groups and minorities in the community, and supports others to take action and achieve social change.

Finally, service providers must create an environment that increases the ability of and gives the right to women to control reproductive decisions, including family size and the timing of births, and enables them to feel free and informed to decide for themselves whether they utilise family planning services. This outcome is more optimal than specifically aiming to

increase the uptake of these services. To do this requires more training, aimed at having a health accountability management system, reducing the cultural and competency gaps identified in the management system and in the information transfer between management and service providers and between the service providers and community.

5.7 Limitations

This study examined the perceptions of 30 Syrian refugee women aged 18 – 49 living in Zaatari camp. While the number of focus group discussions provides a rich data source, the group cannot be said to represent all of the women who live in the camp nor could this study's findings be generalized to all other Syrian women living in different contexts outside the camp in Jordan.

Guidance needed to estimate saturation of sample size were not obtained prior to data collection. The researcher justified the sample size based on achieving meaning saturation for deep level of understanding of the community as a whole and not per target group and taking into consideration the observations made and information collected prior to the data collection process, which were not documented. It is possible that there are further perspectives and views among women in this demographic, but these were not conveyed by the selected participants.

Participants were recruited by Syrian community leaders (gatekeepers) with the support of Jordanian social workers using purposive sampling. As these individuals have worked in the camp for several years, and some live there, bias in the participant selection process may have occurred, whereby these people may have identified participants with whom they were familiar and thought of as being likely to take part in the study.

It is possible that the hardest-to-reach women in the camp were not approached to participate in this study. These women could be facing the greatest challenges in utilising family planning services, particularly if they were unable access the centre and unknown to the recruiters. Having to spare two hours to attend an interview may also have been a barrier to participation.

The women's level of disclosure and ability to share their stories during the focus group discussions varied due to the set-up and the nature of discussing this sensitive topic in this conservative community. Formal sexual education does not exist in the Syrian community and talking about the uptake of contraception is not a normal or common topic of discussion. This may have affected the quality of the data collected in terms of depth and transparency. Moreover, voices of divergence might be silenced as some of women may not have wanted to express an opinion that was different from the rest of the group. That was one of the limitations and another reason for splitting women into the five year age groups to limit the possibility of women holding back opinions in case older women disapproved.

The study did not include young women aged under 18 years, with whom family planning interventions should start. These women were excluded as they are considered a vulnerable population in this context, and extra measures would be required to ensure their protection and safety in the camp. Furthermore, their inclusion in this type of study could have

subjected them to the risk of harm if their family or community perceived them to be sexually active outside of marriage.

The scale of this study is small focused on obtaining women and services providers perceptions only and excluded men, mothers and mothers-in-laws. This may affect the results as it does not give a full perspective of dynamic within the family structure. However, increasing number of participants may also affect the depth of findings.

The researcher is a Jordanian national and native Arabic speaker who works in a United Nations agency, which in one way helped to facilitate the research process and to accelerate building trust with the women. However, this may have hindered women and social workers from being open and sharing their issues related to services, as the researcher's background and position could have been perceived as possibly affecting the social workers' job security or the women's access to aid.

Data collection was conducted in a time period during which there was a rumor circulating of the possibility that services would be shut down and that inhabitants would be forced to start returning to Syria. This affected the morale of women negatively as their priority was to secure their future and a sense of stability. However, after consultation with social workers and community leaders a decision was made to postpone the data collection until things clarified and cleared.

Chapter 6: Conclusion

This chapter will present a summary of the study and a succinct answer to the research question. It will acknowledge and discuss the limitations of this study. Finally, it will present some of the practical recommendations discussed earlier for enhancing the reproductive health services in the camp and reflect upon the contribution to knowledge about women's perception of the utilisation of reproductive health services and the impact of equality, empowerment and cultural sensitivity on the use of these services, as well as providing a direction for further research.

6.1: Summary

Four main factors emerged from the FGDs and KIIs, to answer the study question and to understand the factors affecting the utilisation of family planning among Syrian women aged 18-49 in Zaatari camp, Jordan; which are lack of power and agency among women in the camp, barriers related to social and community norms, challenges related to the structures of power within the family which advocate against the use of such services, and finally interventions that are culturally insensitive and do not correspond to women's needs. The study explored too how empowerment can benefit women, and how facilitating an enabling environment and opportunities can help women make their own decisions regarding their reproductive health.

The study shows that, most women were not found to be in a position to make free choices for a multitude of reasons related to personal beliefs, interpersonal or structural factors. Matriarchal figures like mothers-in-law continue trying to protect their culture and identity more than ever before. Looking at the cultural structure, it seems the key to the utilisation of family planning services is not the potential users themselves but rather the wider context and culture that the women live in. This study shows that in order for women to be empowered to make free and informed choices about their reproductive health, their social and cultural setting must be taken into account. Moreover, service providers should respond to the needs of women in a culturally sensitive manner to enable women to take their own decisions.

In the camp context, the domination of conservative ideas is not the only factor that affects the utilisation of family planning services. Some of the women in the camp were found to have internalised and accepted these ideas as legitimate, using them as ways of exercising power over others. However, other women may be forced to live under these conditions due to the pressure of their mothers-in-law, community or men who exercise power over them to internalise ideas that are not in the interests of women in general.

Health professionals and social workers are not in a position to judge a culture as being right or wrong as perception is relative and they should not communicate their thoughts or beliefs to women. Providing health services is not about persuading women to choose whatever service providers recommend. Service providers need to question their agenda and make

sure that they themselves are not exercising power or influence over women. Instead, they must support and enable women to empower themselves to make a choice, explaining health consequences and understanding their world view. Sweeping long-rooted ideas aside for a new point of view is not a practical or legitimate practice and could be interpreted as the forcing of a more Westernised perspective upon vulnerable women.

The tension between the universalist human rights perspective and cultural relativist perspective is one of the issues to be considered. Service providers need to position themselves somewhere in the middle of this continuum, as either end of the continuum is unsatisfactory for women. Since women are impacted by different factors, service providers need to understand all possible implications of the interventions and how to practically resolve tensions, even if this results in an outcome which is not ideal from the service provider's perspective.

'Negotiated order' gives a practical way in which empowerment could be delivered in a culturally sensitive way, respecting the social order or organisation that exists in communities, constructed though day to day interaction between individuals in a changing structural environment. Negotiation can lead to a shared meaning and questioning of why people play the roles they do and follow the formal rules that they feel they must obey.

This study recommends enabling women to negotiate a different set of rules to live by as a key step of the empowerment process. Many opportunities exist for the improvement of negotiation of status and rights, such as between husbands and wives and between women and their mothers-in-law and service providers. The process is not necessarily determined by existing roles but the well-established family norms and values impact on this process. This would ideally start with a negotiation to start constructively questioning laws and norms. Older women could play a useful role as they already have children and they can spread knowledge while being seen as a more respected and legitimate source when advocating and raising awareness in the community. Alongside this, supporting women to continue in their education and strive to become financially independent can give them the courage to start negotiation.

It must be stressed that that the ideal outcome is not for a woman to visit the clinic and return having been told how her life should be lived. Immediate behavioural change is not necessarily positive as it may lead to rejection from the community. Rather, a gradual and progressive level of support throughout the negotiation process is optimal. The negotiation must focus on the benefit of family planning services in terms of improving reproductive health, making life easier, spacing out children in order to best help women reflect on and see the value in their life.

The process is not a quick fix, rather it is an interactive and organic evolution, enabling the community to question itself and consider how to effect change in a beneficial way. This requires involving many actors in a process of change, adjusting, adapting and accepting in an incremental manner over the timeframe of several years. This time is necessary for the community to make sustainable progress and allow more studies to understand social norms and behavioural change factors related to family planning service utilisation.

Going back to the research question "What are the factors that affect the utilisation of family planning services among Syrian refugee women aged 18-49 years in Zaatari camp, in Jordan?" and the objective of the study to enhance the quality of family planning services in the camp. The researcher focused on

1. Understanding the challenges and motivations that influence their decision or ability to access reproductive health services in Zaatari camp from the women's perspective.
2. Exploring the challenges and motivations that influence women's decision or ability to access reproductive health services in Zaatari camp from services providers' perspectives.
3. Explore potential solutions to enhance family planning services in Zaatari camp from refugee women and services providers perspective.

Thirty women (aged 18-49 years) living in Zaatari camp and 10 services providers working in and outside the camp and at different levels participated in the FGDs and KIIs respectively, to help find an answer to the research question. After a thorough thematic analysis of the data generated, four main themes were found to influence the women's utilisation of family planning services. These four themes were discussed in the light of three theories: Lukes's framework, Dahlgren-Whitehead's 'rainbow model' and 'negotiated order' theory. From this discussion, recommendations were developed and are presented above. These are intended for decision makers and service providers working in the camp to address in their strategies and interventions to enhance the health services in the camp.

6.2: Significance of research and contribution to knowledge

Despite the limitations mentioned in chapter three, this study generated new knowledge and understanding of the decision-making process for family planning service utilisation among Syrian women in the camp. Building on previous published literature and by exploring the perceptions of women, health professionals and social workers, the study found that women in the camp are divided into three groups: women who believe in the concept of family planning services and use the services; women who want to utilise services but are unable to do so due to external pressure; and women who do not want to use services for various internal and external reasons. Looking deeper into the challenges women experience and the barriers women face in relation to utilising reproductive health services in Zaatari camp, the study reveals that the main factor influencing the utilisation of family planning services is women finding it difficult or impossible to negotiate the topic with their spouses and mothers-in-law. This is dependent on the level of power they yield and whether their environment is supportive. It is affected by the pressure of social norms, tradition and culture that expect women to have many children, mainly male, to preserve tradition, maintain the status quo of the tribe and fulfil other social and economic needs.

The study also reveals that despite all efforts made by the government to provide accessible reproductive health services, service providers are not sufficiently trained to discuss and design a culturally sensitive programme that fits each woman's need and complements their daily life routine. They are also unable to support women through their negotiation with their spouse as they consider this barrier to be difficult to overcome. Thus, they usually go with a

no harm approach as the easiest way to protect women from the potential risk of domestic violence and neglect associated with women being in opposition to the community norms. The study proposes change should happen from within, where a woman will be able to decide about her reproductive life with community support for her decision and service providers would be able to support each woman to take a decision that aligns with her will and the common norm.

6.3 Recommendations

Recommendations are presented here to enable the Ministry of Health and humanitarian agencies working in the camp to enhance the visibility of reproductive health services and design a scientific based family planning programme. These recommendations were developed based on the findings in chapter four and the discussion in chapter five.

Recommendations for policymakers at government level

- To prioritise and provide a range of accessible educational opportunities for young women, as this would contribute to facilitating an enabling environment for women to access services and make informed decisions about their reproductive health.
- To introduce policies that support women's participation in the labour force and in community development, to promote the role of women socially, and encourage their practical participation

Recommendations for practitioners at central and camp levels

- To develop and implement a scientific based social norms and behavoral change programme aiming to create an enabling environment where women can negotiate, discuss and express their opinion, and dismante structural inequalities that restrict their ability to express their interest in a self-determined and responsible way.
- To assist empowered women and key actors in the community, who could then act as role models, to design with community-led initiatives which support less empowered women. This could inlcude helping women present their ideas, decide the extent of change they want to make in thier community, support them to make sustainable progress, feel the difference of the change they bring about, and to promote it to other women.
- To enhance service providers skills to design a culturally sensitive women-centred programme that fits each woman's needs, complements their daily life routine, and enables women to empower themselves to make autonomous decisions.

Recommendations for researchers

This study provides an insight into the community-level perceptions and experience of family planning services among Syrian refugee women in Zaatari camp. However, given the limitations of the study mentioned above, there is a need to conduct the following:

- A quantitative and qualitative mixed methods study targeting all camps community segments (e.g, men and mothers-in-law) to understand the social norms and behavioural change factors influencing family planning service utilisation.

- To understand the level of women's empowerment, the factors contributing to it and its impact on a woman's decisions in the camp context or in relation to the utilisation of reproductive health services in a humanitarian context.
- Assist the capacity of the health service professionals around the concept of family planning, with a focus on studying their needs in term of appropriate training, tools, mentoring, incentives and resources to maximise their positive impact.
- To evaluate the existing programme by a third party institution to assess the impact of the reproductive health and women's empowerment interventions in the camp.

6.4: Final note

This study shed the light on the fact that for women in the camp to enjoy their reproductive health rights, they need to be empowered to negotiate the number of children they give birth to and the intervals between births with their spouses and others who have an influence on their decision. With the complication of being a refugee in camp, living in conservative society which is trying to maintain the status quo, 'negotiated order' comes to be identified as a practical way to recommend to women to reach their objective in a culturally sensitive way, where they can respect social order or organisation that exists in communities and at the same time manage their day-to-day needs. Negotiation can help women to also question their role and at the same time follow the rules set in the community by tradition and culture. For that to happen, humanitarian agencies working in the camp must build the capacity of service providers to better enable female empowerment and support them take an informed decision, implement social norms and behavioral change programme to change the overall perception of women role in community beyond being childbearing and finally advocate for more opportunities to women, to support their continue education and become financially independent, all of which can give them the courage to start negotiation and enjoy their reproductive health rights.

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Annexes

I. ANNEX: *Checklist for all researchers*

Research Ethics Approval Committee for Health

Department for Health

The Department for Health requires all members of staff and students who are planning research or consultancy projects to consider the ethical implications of the work which they undertake. This is important in all research and consultancy projects but is ***essential*** in those projects which involve human participants.

The Department has agreed on an ethical review process which has a fast track for those projects which either do not have ethical implications and thus do not require full scrutiny, or where scrutiny will be given by another body (in particular an NHS Research Ethics Committee [REC]).
Projects that fall outside of these categories will need to make a full submission to the Research Ethics Approval Committee for Health.

SECTION ONE

Name *(PI or Student and Supervisor)*	Ruba Hikmat / Dr. David Wainwright
Project Title	Women's health in humanitarian context: A qualitative study to determine factors affecting the utilization of family planning services among Syrian refugee women (18-49) in Zaatari camp, Jordan

Please **tick** the description that applies to your project

Externally funded research project		Consultancy		PhD/PD/RPD/MD/MRes/MSc research project	
Unfunded research project	X	KTP			

SECTION TWO

Determining the nature of your research and
the route for ethical approval you need to follow

Described below are 4 routes for ethical approval (A-D) with corresponding research project features. Please read through all and **tick** the description that applies to your project.
Provide the completed and signed documents as detailed in the corresponding grey box to the REACH Secretary. If you have any queries as to which option to select, please contact the REACH Secretary for guidance.

✔

A. SUBMISSION OF EIRA1 FOR NOTING AT REACH

1	My proposal is currently at the stage of application for funding	
2	My research project does not involve the use of human subjects or data from human subjects	
3	I intend to request the University act as Sponsor for my research. Apply for University Sponsorship. *N.B. subsequent Option D pathway below will be required once University Sponsorship and NHS REC approval have been granted.*	
• this Annex One • EIRA1 (Annex Two or Three)		

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O

B. SUBMISSION OF EIRA1 AND EVIDENCE OF APPROVAL FROM OTHER UNIVERSITY OF BATH ETHICS COMMITTEE FOR REVIEW BY REACH

4	My research has received approval from another ethics committee within the University of Bath, e.g. SSREC for ESRC funded projects, Psychology Ethics Committee
• this Annex One • EIRA1 (Annex Two or Three) • Application and Approval letter from other University of Bath Ethics Committee N.B. Annex Four is not required (as detailed in section C)	

C. FULL CONSIDERATION IS REQUIRED BY REACH

5	My research involves human subjects and does not take place in an NHS context	X
6	My research involves the collection human tissue that will be destroyed within a matter of hours or days and certainly no longer than a week.	
7	My research project involves analysis of secondary data originating from human subjects	
8	My research involves human subjects and takes place outside of the UK, and for which particular consideration needs to be given	
9	My research involves working with children and/or vulnerable adults	
10	My research has received approval from another UK University ethics committee	
11	My project takes place in an NHS context but has been categorised by NHS local R&D as a service evaluation, clinical audit, surveillance or usual practice.	
• this Annex One • EIRA1 (Annex Two or Three) • Annex Four & attachments *(Annex Four is not required if approval from another ethics committee within the University of Bath has been received, see category B. above)* • Annex Five (Option 6 only) • Where available, evidence of consent to use secondary data for the purpose of the proposed project (Option 7 only) • Confirmation the University Child Protection and Safeguarding Policy will be followed (Option 9 only) • Application and Approval letter from other University Ethics Committee and details of Bath staff/student specific role and responsibilities (Option 10 only) • Confirmation of approval that study can be conducted at a specific NHS site (Option 11)		

D. FULL NHS REC CONSIDERATION IS REQUIRED BY THE APPROPRIATE NHS REC, SUBMISSION OF DOCUMENTS FOR NOTING BY REACH

12	My research meets the requirements for submission through the HRA IRAS system, that is, includes: • access to NHS patients • adults lacking capacity • collection and storage of human tissue (i.e. human tissue not destroyed within a matter of hours or days and certainly no longer than a week). • the use of ionising radiation • a clinical trial of an investigation medicinal product (CTIMP)	
• this Annex One • NHS REC approved study protocol, Participant information sheet and Consent form • Formal confirmation of NHS REC approval • EIRA1 (Annex Two or Three) • Annex Five (if study involves collection and storage of human tissue) • Details of who is Sponsoring this project		

1) *ANNEX:* Ethical implications of postgraduate research project

Department for Health

Research Ethics Approval Committee for Health

ETHICAL IMPLICATIONS OF POSTGRADUATE RESEARCH PROJECT

This template should accompany the postgraduate research student application for candidature form submitted to the Board of Studies.

(Additional departmental information may be incorporated as appropriate).

Please note that this procedure is intended to help student and supervisor consider ethical implications of the proposed research project, and as such is a 'light-touch' approach. Supervisors are responsible for deciding whether a more extensive ethical review is necessary (such as submission to an NHS REC).

To be jointly completed by the Student and Supervisor

Title of Project	Women's health in humanitarian context: A qualitative study to determine factors affecting the utilisation of family planning services among Syrian refugee women (18-49) in Zaatari camp, Jordan
Brief Description of Project (max 300 words)	Jordan is a home to 656,000 registered Syrian refugees, 75% of whom are women and children. More than 82% of refugees live in urban settings, while around 18% are living in four camps situated in the north-east part of Jordan, of which Zaatari camp is the biggest with a population of 80,000 (UNHCR, 2017). The Syrian crisis and influx of refugees has changed Jordan's population demographics, and added a huge strain on the national system, including health services (JRP, 2015). Reproductive health care is one of the most established public service programmes in Jordan (JRP, 2015). Almost 60% of Jordanian women of reproductive age (Jordan Department of Statistics, 2012) and 50% of the Syrian women of reproductive age living in host communities use family

	planning methods (HPC, 2016), while only 20.4% Syrian women in Zaatari camp use family planning methods (UNICEF, 2014), despite the fact of the availability of free and accessible health services inside the camp and the high level of awareness of the health and economic benefits of birth spacing (Krause, 2015). Using an exploratory design to assess the under-utilisation of reproductive health services in the Zaatari camp, a full-scale study will include (but not limited to) five focus group discussions targeting 30 Syrian women, age group (18-24), (25 – 29), (30 – 34), (35 – 39), (40 – 49) who use and do not use family planning services and live in Zaatari camp in Jordan. Additionally, the study will draw from ten key informant interviews with reproductive health experts, health and social workers who have at least three years of experience in Syrian crisis response in Jordan. A pilot study conducted in summer 2018 to test the research tools. The pilot study included interviewing two focus group discussions (18 – 24) and (35 – 39) and three key informant interviews. The tools have been reviewed and adjusted accordingly to be used in the full-scale study. The findings of the study will contribute to the enhancement of interventions that aim to reduce maternal mortality and improve women's general health and rights by providing access to reproductive services, but also more broadly by providing insight into decision making processes and household and community power structures that affected women's decision to use family planning services.
Student name and Supervisor name	Ruba Hikmat Dr. David Wainwright
Contact email and telephone number	Rak39@bath.ac.uk [redacted]
Previous ethical approval	Yes / No If YES, please state which body has given approval and the date of approval:

SECTION 1: COMPLETION FOR ALL RESEARCH

Are there ethical implications concerned with the following general issues? *If yes, please provide details below*	
1. Data collection, handling and storage (eg Confidentiality – for consultancy projects, please refer to the confidentiality clauses within the contractual agreement - security, availability, length of storage, etc?) Please review information on the Introduction to Research Data Management website at: http://www.bath.ac.uk/research/data/introduction.html	All electronic data will be stored in the researcher's security protected laptop. A copy of the files will be stored in an extremal drive and stored in the researcher's office in a locked drawer. The researcher and academic supervisor will have access to the study The names of the participants will be replaced with a coding to ensure anonymity and confidentiality in reporting the findings. The hardcopy of transcripts, notes, and voice record files will be destroyed after transferring data into electronic files. Data collected will be kept for at least ten years, for possible use in the future along with the signed consent forms
2. Security Sensitive Reporting (eg Could any of your research material be considered to be supporting terrorism? If so, how have you determined that its use is necessary and ethically justifiable? Such research must also be reported to the University Secretary)	N/A
3. Freedom to publish the results (eg Are there any restrictions raised by contract terms?)	The results of the study will be presented in the reproductive health sub-working group, which includes members from UNFPA, WHO, UNHCR

	and UNICEF, Jordanian Ministry of Health, INGOs and the Camp's management.
4. Future use of findings (eg are there any ethical issues in how the findings will or could be used in the future?)	The findings will be used by humanitarian agencies to enhance the reproductive health intervention inside Zaatari camp.
5. Risk assessment (eg Have issues been raised in the course of identifying and assessing hazards (a substance or situation that might cause harm)? Is there likely to be any damage to / effect on the environment? Please consult the Hazard and Risk Management website at: http://www.bath.ac.uk/hr/stayingsafewell/hazard-risk-management/index.html)	The security situation inside Zaatari camp is unpredictable, a few incidents of violent fights and riots have been reported inside the camp. The researcher is a UN staff working currently for UNICEF Jordan office. The UN Security Management System (UNSMS) ensures the safety, security and protection of the staff during her visit to the camp. The researcher will be in direct contact with the United Nation Security Section and Public Security Department in Jordan. The researcher will move in United Nation vehicle and use United Nations facilities inside the camp which are all secured and protected. So, if any incident occurs or there is any potential risk arise, the security office in the camp intervenes immediately and secure a smooth evaluation of the UN staff. The researcher will obtain security clearance two-day prior the visit to the camp. The researcher is already trained on advanced security in the field and have more than ten years of experience working in emergencies. The researcher will be equipped as a United Nations staff with communication tools linked with the security office in the camp.
6. Conflicts of Interest (eg Are you involved in any other activities/collaborations/ relationships that may result in a conflict of interest with this research?)	N/A
7. Competency to conduct research/project. (ie Do you lack any knowledge or skills compatible with the demands of the investigation to be undertaken? If yes, indicate how will you address this.)	N/A

8. Compliance with professional body Codes of Conduct (ie Is there anything that would prevent the research being conducted in compliance with professional body standards?)	N/A
9. Location of research (ie Will the research involve lone working or travel to areas that may be unsafe or at risk? In your considerations, you may find it helpful to review the Fieldwork website at: http://www.bath.ac.uk/hr/stayingsafewell/working-off-site/fieldwork-placements/index.html)	The proposed location where the focus groups discussion will take place is secured and protected by United Nations security system.

Demonstration of Ethical Considerations
Please outline the ethical issues which will need to be managed during the course of the activity.

The researcher will consider carefully the ethical implications during the research; preparation, implementation, documentation and dissemination processes

Ensuring the quality and integrity of the research

The researcher will use the improved tool that have been adjusted based on the results of the pilot study. During the pilot phase, the researcher examined the study's method and procedures, evaluated any ambiguity in the questions, tested the flow of discussion, time, feasibility and the questions' reliability and sensitivity. The original tools have been formulated after reading literatures and relevant publications and the process of development done in consultation with reproductive health experts and in participation with Syrian refugee women community leaders (gatekeepers).

In the study, the researcher will focus on understanding the factors and the challenges that hinder Syrian women to utilise family planning methods and space between their deliveries, the findings of the study will be translated into recommendations for humanitarian agencies working in the camp, that they can use as a reference to enhance women's wellbeing and promote their development in the camp, and in consequence it may contribute to improve the health and development of the community and society.

The researcher sent the protocol to relevant United Nations agencies who manage the reproductive health clinics and women centres in Zaatari camp, and who interact with Syrian women in daily basis. The researcher has been conducting on-going consultations with reproductive health professionals and decision makers to ascertain the value and benefit of collecting data versus how any risks this research may pose on individuals in the camp, and how much it may contribute practically to the women's life and well-being.

A brief note in Arabic sent to the camp's manager and reproductive health working group to assure their support and protection throughout the implementation process of the research.

The researcher sent the study's ethical form to the management of the camp for information only. The form includes the research protocol, participants' consent forms, participants' information forms, interview guide, examples and interview schedules. Worth to mention that no formal ethical consent form is requested by the camp or the United Nation agencies

Ensuring that women will participate in the study voluntarily

The recruitment process of participants will be in a consultation with the social workers who work in the women centres in Zaatari camp. The social workers are trustable and have been in the camp since its establishment, they are familiar with most of the women and their families and they can play the role of caregivers. To assure that the research process will not harm any of the participants and none will be at risk of harm, the researcher will ask the social workers at the women centre to identify and approach women prior the research (from women visiting and not visiting the centers), introducing them to the rationale behind the participation, risk and benefit of participating in the research and give them at least a week time to consult the idea of participation with their families. Will seek the support of the social workers to introduce the researcher to the women who show interests and decide to participate in the research.

The researcher will make it clear for women that their participation should be voluntary and no obligation on them to take part in the research. The researcher will explain to the participants the rationale behind their participation in study and make it clear that the quality and access to health services will not be affected by their decision of participating in the research. Will confirm and make clear to state in the information sheet that decision of participation will not affect the services provided and their patriation is voluntary and will seek the support of the community leader to support the women's full decision of not feeling obliged to be part of the study. The researcher will explain before the interview starts the privacy and confidentiality risk of participating in the interview. The researcher will inform participants not to repeat what is said in the focus groups to others and will remind them of the potential consequences and harm it may cause disclosing or sharing personal information. The researcher will make it clear to participants that she cannot promise or ensure that other women in the group will respect the confidentiality of all participants' information. The researcher will state these points in the information sheet and will seek the support of the social worker to emphasize on that during the recruitment process.

The researcher will inform the humanitarian agencies, who manage and fund the services provided in the camp to apply needed measures to assure confidentiality. Worth to mention, the sub-working group are mandated to maintain and assure the provision of equitable and accessible services to all refugees inside the camp. The women space where the interviews will take place provides gender-based violence, reproductive health and lifestyle related services and the whole workers there are trained on ethical principles and human rights issues. The institutions who manage services in the camp are committed to provide services to all refugees equally and they are under close and regular observation and auditing. The researcher will coordinate with the community leaders to make sure that none of the participants gets harm as a result of participation and will ask them to emphasise on the important of reminding the participants of their rights to report any concern or complain to the online help desk, hotline or to participate in the biweekly community meetings which usually organise in the camp to receive feedback on the services.

Seeking informed consent

Prior collecting the data, the researcher will visit the identified participants' in a neutral place where they feel comfortable and relaxed in a step to build a trust, develop personal relations and break communication barriers. Will discuss with women their day-to-day issues, such as, the number of children they have, how they manage time, how they can divide attention between house, spouse and children, how they prepare for

traditional wedding celebration and what is the role of mother and mother-in-law in the Syrian community…etc. Will explain verbally in a simple Arabic language the objectives and nature of the study, risk and benefit of participating in the research, the proposed place where the findings will be published, the language and how the results will be used. Moreover, Will distribute an information sheet (see appendix 1) about the different aspects of the study and give them a week time to think and consult with their relatives and family before responding and confirming to the social workers.

The researcher will distribute to the participants-who accept to participate in the study- a consent form in Arabic includes a check list to help them tick and indicate their preservations in regards of certain information to share and their willingness to participate voluntary in the study. Will explain the content of the consent form (see appendix 2) and clarify to participants that they have the right to withdraw from the interview before it starts and a week period of time after completion of data collection. Moreover, they will be informed that they have the right to skip questions during the interview.

After obtaining consent (verbally as well as written) and prior collecting data, the researcher with the social worker will discuss with participants the preference location and time to conduct the focus group discussions and will take permission to record the discussion. The initial proposed location based on experience and after initial discussion with social workers in the field is the women centre, which attracts different age group of women - who use and do not use contraceptive- during their leisure time. The location gives women a space to share their personal thoughts and experiences away from their family's members and in a private setting.

Protecting the participants and researcher during the process of collecting information

The study will exclude women below the age of 18 in the study as they considered a vulnerable population and extra measures are required to ensure their protection in the camp. Further, involving young women in discussions on sexual and reproductive health is strictly forbidden. Their inclusion in this type of study could subject them to harm if their family or community perceives them to be sexually active outside of marriage.

The researcher will take safety into consideration, will approach the camp manager seeking their support to review the names of participants and to make sure that the names of all participants are cleared, and no one has a security issue. Moreover, will ask the security team's support to protect the place where the focus group discussion will take place. The researcher will stay in contact with the camp manager and the United Nation security officer to make sure all security measures are implemented, and no potential security risk is in place during the process of collecting data. The researcher will obtain security clearance two days prior the visit to the camp from the public security department. The researcher will ask the social worker in the women center to participate in the focus group discussion, if women approve that. The social workers are trained to identify gender-based violence cases and will apply required procedure, if needed, for case management in a professional way using the referral guide and standard operational procedure.

In addition to that, the researcher will dress appropriately and be culturally sensitive to Syrian context. Will speak in the participants' language and read more about the culture and tradition prior the visit.

Specific Issues		
10. **Does the research/project involve human participants in any way? (**Please note if you are processing personal data you need to tick 'Yes'.)	Yes	Complete Section 2
11. **Does the research/project involve animals in any way?** Please note that this includes all creatures (vertebrates and invertebrates) and their cells or tissues, whether living or *post mortem*	No	Complete Section 3
12. **Does the research require ethical approval by SSREC, REACH, Psychology Ethics Committee or the University Ethics Committee Panel?**	No	Please give details of Committee and date of review

Declarations

I confirm that the statements in Sections 1-3 describe the ethical issues that will need to be managed during the course of this research activity and that consideration has been given to whether further ethical approval is required and how this will be sought.

Principal Investigator/ Supervisor/Project Supervisor	**Signature: Dr David Wainwright** **Date: 17 Jan 2019** **Print Name: Dr David Wainwright**
Second reader(PhD/DHealth/ MPhil/MD only)(normally external to the project team)	**Signature: Alan Buckingham** **Date: 17 Jan 2019** **Print Name: Alan Buckingham**
Researcher/Student	**Signature: Ruba Hikmat** **Date: 17 Jan 2019** **Print Name Ruba Hikmat**

Please return this form to the Secretary for the Research Ethics Approval Committee for Health (REACH). (Issues will be monitored for incorporation into an annual departmental report to be submitted to the University Ethics Committee.)

SECTION 2: FOR COMPLETION IF YOUR RESEARCH INVOLVES HUMAN PARTICIPANTS

If any of the answers to these questions are 'yes', please confirm in the space below how the ethical issues will be managed during the course of the activity.

Compulsory question for consideration by all disciplines:

	Yes	No
Will the study involve obtaining or processing personal data relating to living individuals, (eg involve recording interviews with subjects even if the findings will subsequently be made anonymous)? *Note: If the answer to this question is 'yes' you will need to ensure that the provisions of the Data Protection Act are complied with. In particular you will need to seek advice to ensure that the subjects provide sufficient consent and that the personal data will be properly stored, for an appropriate period of time). Information is available from the University Data Protection Website http://www.bath.ac.uk/internal/data-protection/ and dataprotection-queries@lists.bath.ac.uk Note: For Consultancy Projects you are encouraged to ask the client to arrange/liaise with living individuals and have the data delivered to you for analysis.*	X	

Departments may amend the following list to include topics of particular relevance to their discipline(s).

	Yes	No
1. Does the study involve participants who are particularly vulnerable or unable to give informed consent? (eg children, people with learning disabilities)	X	
2. Will the study require the co-operation of a gatekeeper for initial access to the groups or individuals to be recruited? (eg students at school, members of self-help group, residents of a nursing home)		X
3. Do you require a DBS (Disclosure and Barring Service) check and if so have you obtained the necessary documents and approval?		X
4. Will it be necessary for participants to take part in the study without their knowledge and consent at the time? (eg covert observation of people in non-public places)		X

	Yes	No
5. Will the study involve discussion of sensitive topics? (eg sexual activity, drug use)	X	
6. Are drugs, placebos or other substances (eg food substances, vitamins) to be administered to the study participants and/or will the study involve invasive, intrusive or potentially harmful procedures of any kind?		X
7. Will blood or tissue samples be obtained from participants? *Note: If the answer to this question is 'yes' you will need to be aware of obligations under the Human Tissue Act, see further information at http://www.bath.ac.uk/research/governance/ethics/hta.html*		X
8. Is pain or more than very mild discomfort likely to result from the study?		X
9. Could the study induce psychological stress or anxiety or cause harm or negative consequences beyond the risks encountered in normal life?	X	
10. Will the study involve prolonged or repetitive testing?		X
11. Will financial inducements (or other expenses and compensation for time) be offered to participants?		X
12. Will the study involve recruitment of patients or staff through the NHS? Note: If the answer to this question is 'yes' you will need to submit an application to the NHS through IRAS (Integrated Research Application System), see: http://www.hra.nhs.uk/research-community/applying-for-approvals/		X

Section 2: Demonstration of Ethical Considerations

Please complete this section if any of the answers to the above questions are 'yes'.

Given that the topic of the research is very sensitive, the researcher will seek the support of the social workers, health workers and community leaders at Zaatari camp to identify psychological, security and social relevant potential risks at the individual, family and community levels and to propose best mitigation measures to minimise any potential risk, even before it occurs.

The sexual reproductive health is not an easy subject to discuss in refugee camp. The researcher will make sure not to push participants during the interviews to discuss things that distress them or offend them in a way or another and will not raise any question that expose participant to trauma or discomfort. Moreover, with the support of the community leader, The researcher will make sure to select appropriate and culturally sensitive questions when discussing sensitive issue and speak in simple Arabic language. The researcher will make sure not to affect the participant's personal life negatively (intentionally or unintentionally) or interfere in the women's personal life, her relationship with her husband or any family members.

The researcher will seek the support of social worker (psychologist/counsellor) to participate in the interviews (if participants agree), to make sure that no one is harmed throughout the process of the study. The social workers at the center are trained to identify gender-based violence survivors and apply case management measures, using the referral guide and standard operation procedure. The researcher will offer women who experience distress from participating in the study, a listening and counselling sessions in the women center in the camp.

The interviews and focus group discussions to be conducted in accordance with the United Nations ethical principles of reporting and code of conduct.

Respecting the confidentiality, privacy and anonymity of the research respondents

Discussing sexual and reproductive health issue in a conservative community such as Syrian refugee population is rarely done. Sexual education is not existed among Syrian community and talking about the uptake of contraceptive is not a normal or common topic of discussion. The researcher will respect participants, their values, beliefs and preferences, by understanding their profile, spend time prior the interview and built trust with participants at least once before the interview. The researcher will take advice from the community leaders and social worker throughout the process so as not to offend or upset any of the participants.

The method of qualitative studies requires collecting personal information. In order to make sure that no personal information is leaked or passed, the researcher will develop a strategy to collect data taking into consideration ethical principles and will apply no harm approach during the interview and documentation. The researcher will explain before the interview starts the privacy and confidentiality risk of participating

in the interview. The researcher will inform participants not to repeat what is said in the focus group discussions to others and will remind them of the potential consequences and harm it may cause disclosing or sharing personal information. The researcher will make it clear to participants that she cannot promise or ensure that other participants will respect the confidentiality of all participants' information. The researcher will state the points in the information sheet and will seek the support of the social worker to emphasize on it during the recruitment process.
The information will remain anonymous and identifier components will be removed in all process. All data will be anonymised using coding. The information that describes participant personal life (not relevant) or that may identify the participant's identity will be removed. The researcher will consult with the social worker (who recruits the participants) the content of the data collected before starting the analysis process to make sure that none of the data will directly or indirectly harm any of the participants. The researcher is trained on referral and case management system inside the camp. Hence if the researcher hears about any illegal or dangerous health practice, she will report it to the focal point in the reproductive health sub-working group, who from their side will follow up and provide accurate advice, if required. While if the researcher observes or hears about any gender-based violence act, then she will report that to the social worker, who is advised to participate in the focus group discussion, if participants agree, to take needed action. At the same time will encourage participants to participate in the activities in the women space, where psychological support services and lifestyle/recreational activities are provided free of charge by trained counsellors. The researcher will clearly state in writing who will have access to initial information and how information will be used. Will save anonymised transcripts and e-copy of consent forms in a security protected personal laptop. No one will have access to the personal laptop, except the researcher and the academic adviser. The researcher will keep a copy of the electronic files (anonymised transcripts and e-copy of consent forms) in an external drive in a safe secured place and will upload the anonymised transcripts on the UsB's X drive as soon as transcripts are developed. Moreover, will replace the names of the participants of the key informant interviews, if required, with a coding to ensure anonymity and confidentiality in reporting the findings. The researcher will destroy the hardcopy of transcripts, audio voices and notes after transferring data into electronic files.

SECTION 3: FOR COMPLETION IF YOUR RESEARCH INVOLVES ANIMALS

	Yes	No	In progress
1. Has the project been submitted to and approved by the Animal Welfare and Ethical Review Body? You should contact the Animal Research Liaison Officer (ARLO: arlo@bath.ac.uk) to register your project. All projects involving animals must be registered with the ARLO and approved by the local Animal Welfare and Ethical Review Body (AWERB).			
2. If your project is governed by the Animals (Scientific Procedures) Act incorporating EU Directive 2010/63/EU [new A(SP)A], have you obtained the relevant Home Office licences?			
3. If your project is not controlled by the new A(SP)A, is it controlled by any other UK legislation? If so, please specify			
4. If the research is not controlled by any of the above legislation, have the ethical implications of the project been considered by the Animal Welfare and Ethical Review Board? Please complete the Ethical Review Form accessible from: http://www.bath.ac.uk/research/governance/ethics/ accessed via Resources/Forms/Animals – Ethical Review Form			

Section 3: Demonstration of Ethical Considerations

This section is available for submission of further details relevant to Section 3.

2) ANNEX: Application form for full submission for research ethics approval

Department for Health

Research Ethics Approval Committee for Health

Title of study	Women's health in humanitarian context: A qualitative study to determine factors affecting the utilization of family planning services among Syrian refugee women (18-49) in Zaatari camp, Jordan
Chief investigator (for research student projects, put Bath research supervisor's name here) (for undergraduate	Name: Ruba Hikmat e-mail: rak39@bath.ac.uk Telephone: [redacted]

projects, put Bath project supervisor's name here)	Dr David Wainwright:
Other investigators (for research student projects, put student's name here) (for undergraduate projects, put student's name here)	Name: e-mail: Telephone:
Source of funding for the study	N/A
Proposed dates of study	Feb – May 2019
Research question	What are the factors that affect the utilization of family planning services among Syrian refugee women aged 18-49 years in Zaatari camp, in Jordan?
Background (less than 100 words)	Jordan is a home to 656,000 registered Syrian refugees, 75% of whom are women and children. More than 82% of refugees live in urban settings, while around 18% are living in four camps situated in the north-east part of Jordan, of which Zaatari camp is the biggest with a population of 80,000 (UNHCR, 2017). The Syrian crisis and influx of refugees has changed Jordan's population demographics, and added a huge strain on the national system, including health services (JRP, 2015).
	Reproductive health care is one of the most established public service programmes in Jordan (JRP, 2015). Almost 60% of Jordanian women of reproductive age (Jordan Department of Statistics, 2012) and 50% of the Syrian women of reproductive age living in host communities use contraceptive methods (HPC, 2016), while only 20.4% Syrian women in Zaatari camp use family planning methods (UNICEF, 2014), despite the fact of the availability of free and accessible health services inside the

	camp and the high level of awareness of the health and economic benefits of birth spacing (Krause, 2015).
Methods (less than 300 words)	The research will apply qualitative methods to better understand the root causes of behaviours and barriers to accessing reproductive health services in Zaatari camp from Syrian women and health workers' perceptions and to generate findings on values, beliefs, and perceptions, as well as individual and group preferences, behavioural patterns and expectations and disparities among different women age groups (18-49). In 2018, the researcher conducted a pilot the study to be able to test the tools and enhance study design further before conducting the full-scale study. The pilot study based on two focus group discussions with women under the following age group (18-24) and (35-39) in Zaatari camp and key informant interviews with three humanitarian and health professionals working on reproductive health services in Zaatari camp who have at least three years of experience in the Syria response in Jordan. The researcher will conduct the full-scale study from Feb - May 2019, collecting data from three focus group discussions (The number of FGDs and KIIs is not limited or fixed, depends on the researcher satisfaction) with women under the following age group (25- 29) (30-34) and (40-49) in Zaatari camp and key informant interviews with seven humanitarian and health professionals working on reproductive health services in Zaatari camp. For the focused group discussions, the researcher will convene small groups of women in safe settings, with the presence of social worker if accepted by participants and will ask set of questions following a semi-structured conversation guide (questions going from general to specific, with probing as necessary to clarify information). The questions will address the women's experience, opinions, feelings, knowledge and other qualitative variables related to their decision or ability to access family planning services. This will cover their personal experience, their interpersonal relation with family and community members as well as the client-medical professional interactions. Women in the focus group discussions will be encouraged to provide insights not covered in directly through the question guide to help overcome limitations in the study construct.

	The researcher will also conduct key informant interviews with professionals in the field to understand from health workers' perspective the barriers, opportunities and challenges to increasing access to and utilization of family planning services. The interviews will utilise open-ended questions in a semi-structured format, and the researcher will listen to answers, probe as necessary and record responses.
	The discussions will be recorded and transcribed in Arabic (the language of participants), then reviewed, checked, translated and typed in English and entered into Microsoft Word for thematic analysis.
Sample size (or equivalent qualitative approach)	Focus group discussions: The researcher will consult the criteria of selection with the humanitarian and health workers at UNICEF and UNFPA and later will approach health worker and community leader in Zaatari camp to review the criteria of selection and revise it accordingly. Focus group discussions, with a total of 18 selected women Three focus groups will be segmented to keep women of similar age groups together, with the following categories of age (25-29) (30 - 34) and (40-49), each focus group will include 6 women. Key informant interviews: In order to document multiple perspectives of social and health workers at the different levels, the researcher will choose purposive sampling for key informant interviews based on criteria that ensures their inputs will be valuable to the study outcomes, such as direct work in family planning promotion, service delivery or policy formation. Key informant interviews will include (n=2) health workers, (n=1) social worker and (n=4) humanitarian stakeholders representing humanitarian agencies working inside Zaatari camp. A schedule of interviews for each method will be developed, reviewed and translated into Arabic.
Proposed Analysis	The researcher will go through levels of thematic analysis, moving from general to more specific analysis to gain a better understanding of the issue, why it exists and to reveal critical and strategic insights to address

	barriers and practical solutions to overcome them (Wainwright, Boichat & McCracken 2014). The data collected from FGDs and KIIs, will be translated and transcribed, while the txt after verified will be coded using NVivo software. The researcher will code every two to three lines of the text with identified key words and concepts. The researcher will read and double check the codes to assure consistency and make sure nothing is missed out. To ensure integrity and accuracy of codes, the codes will be reviewed and checked by another analysist/researcher. After coding the text, the researcher will sort identified codes into themes/categories and sub-themes
Potential risks to volunteers	Participants may disclose sexual violence/abuse.
Potential for pain/discomfort	The Syrian community is conservative, and the topic of the research is sensitive. The researcher will seek the support of social and community leaders for advice and guidance.
Benefits to participants	They will contribute in enhancing reproductive health services in the camp
Will the study involve deceiving the participants? If so, please justify why deception is necessary.	N/A
How will participants be recruited?	During the pilot study, the researcher sent the protocol to the relevant agencies who manage the reproductive health clinics and women centres in Zaatari camp. The researcher sent a brief note in Arabic to the camp manager, health and social workers and community leaders (gatekeepers) in the camp. For the full-scale study, the researcher will make sure that the recruitment process is culturally and socially sensitive with an emphasis that the nature of participation is voluntary. The researcher will identify and recruit potential participants in collaboration with community leaders, following the criteria of selection that ensures respondents are from groups of interest. The researcher will assure that ethical principles is implemented to ensure participant's confidentiality, no harm and respect. The researcher will meet the identified women at least once before the interview in a step to build trust and to introduce the women to the rationale behind the study, risk and benefit of participating in the research and the place where the findings will be published.

	The researcher will provide potential participants with a brief in Arabic about the study, a check list to enable them to indicate their preservations in regards of certain information and their willingness to participate voluntary in the study. The researcher will give the potential participants at least a week time to discuss with their families the possibility to participate in the study and decide. For the key informant interviews, the researcher will approach the United Nations reproductive sub-working groups, management focus points and heads of women centres seeking their advice and support in identifying the best professionals who can enrich the study with knowledge and experience.
	Recruiting children for research studies on sexual and reproductive health is a highly sensitive issue in the social-cultural and humanitarian context of Zataari camp, where involving young women in discussions on sexual and reproductive health is considered taboo and in some cases strictly forbidden. Therefore researcher will exclude girls under the age of 18 in the selection criteria, as they are considered a vulnerable and extra measures are required to ensure their protection in the camp. Further, their inclusion in this type of study could subject them to harm if their family or community perceives them to be sexually active outside of marriage
Exclusion/inclusion criteria	*Inclusion criteria* *Focus group discussion* Women (aged 18 – 49) willingly consented to participate in focus group discussions Women who can spare at least 2 hours to participate in the session Sexually active women of reproductive age, who either do or do not utilise family planning services. *Key informant interviews* Health workers in the reproductive health clinics in Zaatari camp Humanitarian workers working on reproductive health interventions at three levels (working with families in the camp, managing the

	reproductive health programmes and representing different agencies/bodies/communities working in the camp. Participants must have three years total experience working with Syrian refugees, and at least one year's experience in the camp *Exclusion criteria:* *Focus group discussion* Girls under 18, women with known history of infertility or who have serious health problems, women who have mental disorders or who are not able to give valid information. Following the committee's recommendation, unmarried women over 18 will be excluded from the study to avoid any potential harm that may occur as result of participation *Key informant interviews* Health workers who are no longer in the position of direct contact with the refugees. Health workers who have less than three years' experience in the Syria crisis, or less than one year's experience in the camp. Health workers who are less than 18 years of age, or who do not have experience in reproductive health care.
How will participants consent be taken?	Prior collecting the data, the researcher will visit the identified participants in a neutral place where they feel comfortable and relaxed in a step to build a trust, develop personal relations and break communication barriers. Will discuss with women their day-to-day issues, such as, the number of children they have, how they manage time and divide attention between house, spouse and children, how they prepare for the traditional wedding celebration and what is the role of mother and mother-in-law in the Syrian community…etc. Will explain verbally in a simple Arabic language the objectives and nature of the study, risk and benefit of participating in the research, the proposed place where the findings will be published, the language and how the results will be used. Moreover, will distribute an information sheet (see appendix 1) about the different aspects of the study and give them a week time to think and consult with their relatives and family.

	The researcher will distribute to the participants-who accept to participate in the study- a consent form in Arabic includes a check list to help them tick and indicate their preservations in regards of certain information to share and their willingness to participate voluntary in the study. Will explain the content of the consent form (see appendix 2) and clarify to participants that they have the right to withdraw from the interview before it starts or during a week period of time after the completion of the data collection process, and that they have the right to skip questions during the interview time. After obtaining consent (verbally as well as written) and prior collecting data, the researcher with the social worker will discuss with participants the preference location and time to conduct the focus group discussion and will take permission to record the discussion. The initial proposed location based on experience and after initial discussion with social workers in the field is the women centre, which attracts different age group of women during their leisure time, who use and do not use contraceptive. The location gives women a space to share their personal thoughts and experience away from their family's members and in a private setting. After data is collected, the researcher will inform the participants that they have a week time to think and discuss their participation again with their families' members and that they have the right to withdraw from the study, by informing the researcher though the social worker who works in the women center.
How will confidentiality be ensured?	Discussing sexual and reproductive health issue in a conservative community such as Syrian refugee population is considered as a sensitive issue. Sexual education is not existed among Syrian community and talking about the uptake of contraceptive is not a normal or common topic of discussion. The researcher will respect participants, their values, beliefs and preferences, by understanding their profile, spend time and built trust with participants at least once before the interview taking place and will follow the advice of community leaders throughout the process so as not to offend or upset any of the participants. The method of qualitative studies requires collecting detailed personal information. In order to make sure that no personal information is leaked or passed, the researcher will develop a strategy to collect data, taking into consideration ethical principles and will apply no harm approach during the interview and documentation.

	All data will be anonymised, the researcher will hide the name of the participants and follow a coding style. Will clearly in writing state who will have access to initial information and how information will be used. The information will be confidential and identifier component will be removed. Will save all data, anonymised transcript and e-copy of consent forms in a security protected personal laptop. No one will have access to the personal laptop, except the researcher and academic advisor. The researcher will keep anonymised transcripts stored on the university's X drive. Will replace the names of the participants of the key informant interviews, if required, with a coding to ensure anonymity and confidentiality in reporting the findings.
	The researcher will destroy the hardcopy of transcript, audio files or notes after transferring data into electronic files
What aftercare will you provide for participants?	The researcher will provide the participants with information about the services and activities available in the centre, where they can access for free to enable them to get the support they may need. The researcher will ask the support of the United Nation agencies to distribute educational leaflets and brochures about the services and family planning and the contact details of services that they may need. The researcher will also remind the participants of the importance of participating the community biweekly meeting and the hotline where they can share their experiences and expectations. The researcher will offer to participants to meet with the counsellor in the women space in case any feels disconformable or disturbed as a result of participation. The researcher will ask the participant how they feel after participation in the research and ask them about their feedback and how to make it working better when interviewing next FGD
How long will you store *personal* data (including informed consent)? If you are retaining personal data longer than the end of the study, please justify	The researcher will destroy all personal data including the notes, audio files and hard copy of consent forms at the end of the analysis. While, the anonymised transcripts will be stored for 10 years on the university X drive

Attach the following (where relevant):

Community level perceptions of reproductive health services among Syrian refugee women

1. Participant information sheet
2. Consent form
3. Health history questionnaire
4. Poster/promotional material
5. Copy of questionnaire/ proposed data collection tool (questionnaire; interview schedule/ observation chart/ data record sheet/ participant record sheet)
6. Data management plan

Signed by: Principal Investigator or Student Supervisor

Dr David Wainwright Date: 17 January 2019

Signed by: Student or other researchers

Ruba Hikmat Date: 17 January 2019

Appendix 1/A: Information booklet for participants (Syrian women)

Department for Health

University of Bath

Bath, UK.

Women's health in humanitarian context: A qualitative study to explore factors affecting the utilization of family planning services among Syrian refugee women (18-49 years) in Zaatari camp, Jordan

Introduction to study participation

Hello, my name is (***Ruba Hikmat***). I am conducting a research about women's health in Zaatari camp. The research is a requirement for my course of study in the Doctor of Health Programme at the University of Bath. I want to talk to you about peoples' opinions and behaviour relates to factors affecting the utilization of family planning services in the camp. The information you provide will be used to help the government and humanitarian agencies to enhance health services, of which it will contribute in improving the well-being of Syrian refugee women in the camp.

I will be interviewing around 30 women in Zaatari camp about the same topic. You will be in a group consists of six members. The interview should take about *45 – 60* minutes to complete. All information we obtain will remain strictly anonymous and no records of your identity will be kept in relation to your responses.

You are free to decide to take part of this research or not. If you agree to participate, you have the full right to ask for more clarification at any step in the process, to not answer any question if you don't feel comfortable to do that and to withdraw from the study without providing any explanation, either before the interview start or up to two week time after the completion of data collection

Why have I been chosen to take part in the study?

You have been invited to participate in the Focus Group Discussion, as your characteristics are fit into the criteria of selection developed by the researcher in consultation with the Syrian community leader.

What will happen if I take part?

Your consent will be sought before the interview after you fully understand the study's objective, the process, and the use of information. You will be asked a list of questions in a form of focus group discussion. The interviews will be recorded, transcribed in Arabic and translated to English language. The data that will be collected and later analysed and reported.

Expenses benefits and / or payments:

No incentive, compensation, or direct/indirect benefit for your time will be given; the only expense you will incur is your time.

Are there any risks in taking part?

The researcher will apply ethical principles during the interview and throughout the development process of the final report.

You are requested not to repeat what is said in the focus groups to others and not to disclose personal information if you don't feel comfortable to do that. The researcher cannot promise or ensure that other participants will respect the confidentiality of all participants' information.

What will happen to the results of the study?

The study will be submitted to University of Bath for approval, once it is approved, it will be shared with relevant humanitarian agencies who work for Syria crisis in Jordan and with the government of Jordan represented by the Ministry of Health. The study will be developed in English language and will be published on internet.

What if I have any further question? Or if I am unhappy or if there is a problem

I will answer your queries and you can reach me at Ruba Hikmat, rak39@bath.ac.uk 00962790580780

If you remain unhappy or have a complaint, which you feel you cannot come to me, then you should contact the Research Ethics Approval committee for Healht (REACH) at the University of Bath, Rebecca Wise, health-ethics@bath.ac.uk at , on +44 (0) 1225 38 4714.

Thank you very much for taking time to read this information booklet.

Appendix 1/b: Information booklet for participants (Health and social workers)

Department for Health

University of Bath

Bath, UK.

Women's health in humanitarian context: A qualitative study to explore factors affecting the utilization of family planning services among Syrian refugee women (18-49 years) in Zaatari camp, Jordan

Introduction to study participation

Hello, my name is (***Ruba Hikmat***). I am conducting a research about women's health in Zaatari camp. The research is a requirement for my course of study in the Doctor of Health Programme at the University of Bath. I want to capture your opinion in view of your experience and talk about peoples' opinions and behaviour relates to factors affecting the utilization of family planning services in the camp. The information you provide will be translated to recommendations for the government and humanitarian agencies to use aiming at enhancing the quality and accessibility of reproductive health services in the camp.

I will be interviewing other health and social workers about the same topic. This interview should take about *45 – 60* minutes to complete. All information we obtain will remain strictly anonymous, and no records of your identity will be kept in relation to your responses unless you notify us in advance.

You are free to decide to take part of this research or not. If you agree to participate, you have the full right to ask for more clarification at any step in the process, to not answer any question if you do not fool comfortable to do that and to withdraw from the study without providing any explanation, either before the interview start or up to two week time after the completion of the data collection

……

Why have I been chosen to take part in the study?

You have been chosen to participate as you have more than three years of experience in reproductive health or in protection working with Syrian community in Zaatari camp. By participating, you will help us build up the amount of data available for analysis.

What will happen if I take part?

Your consent will be sought before the interview after you fully understand the details, the process, the study's objective and the use of information. You will be asked a list of questions in a form of in depth interviews. The interviews will be recorded, transcribed in Arabic and translated to English language. The data that will be collected and then will be analysed and reported.

Are there any benefits in taking part?

No incentive, direct or indirect benefit or compensation for your time will be given; the only expense you will incur is your time.

Are there any risks in taking part?

The researcher will apply ethical principles during the interview and throughout the development of the final report.The identity of the participants will be kept confidential. The data will be transcribed and kept in a digital format and will not be shared with anyone except the research team at the university.

What will happen to the results of the study?

The study will be submitted to University of Bath for approval, once it is approved, it will be shared with relevant humanitarian agencies who work for Syria crisis in Jordan and with the government of Jordan represented by the Ministry of Health. The study will be developed in English language and will be published on internet.

What if I have any further question? Or if I am unhappy or if there is a problem

I will answer your queries and you can reach me at Ruba Hikmat, rak39@bath.ac.uk [redacted]

If you remain unhappy or have a complaint, which you feel you cannot come to me, then you should contact the Research Ethics Approval committee for Healht (REACH) at the University of Bath, Rebecca Wise, health-ethics@bath.ac.uk at , on +44 (0) 1225 38 4714.

Thank you very much for taking time to read this information booklet.

Appendix 2: Informed consent process

Describe the arrangements for gaining informed consent from the research participants.

Health workers: The consent will be prepared and shared with potential participants. The participant will be asked to read through the consent form and sign if they agree. Syrian women: The consent will be prepared and shared with community social worker at the camp. The social worker will contact potential participants and obtain their consent days before the interviews. The participant will be asked to read through the consent form, discuss it with family members and sign if they agree.

b) **If participants are to be recruited from any of the potentially vulnerable groups listed above, give details of extra steps taken to assure their protection, including arrangements to obtain consent from a legal, political or other appropriate representative in addition to the consent of the participant**

N/A

c) **If participants might not adequately understand verbal explanations or written information given in English, describe the arrangements for those participants (e.g. translation, use of interpreters etc.)**

The interviews will be conducted in Arabic which is the language of participants, and later will be transcribed into English

d) **Where informed consent is not to be obtained (including the deception of participants) please explain why.**

Informed consent will be obtained from each participant

D6) **What is the potential for benefit to research participants, if any?**

The research aims to help understand the root causes for utilization of family planning services in Zaatari Camp. The findings will be used as a recommendation to enhance the services of family planning and address the challenges that women face of which hinder them from enjoying these services and their fundamental reproductive rights.

D7) State any fees, reimbursements for time and inconvenience, or other forms of compensation that individual research participants may receive. Include direct payments, reimbursement of expenses or any other benefits of taking part in the research?

1. None for the in-depth interview participants
2. Refreshments will be served during the FGD session.
3. The researcher will discuss with the humanitarian agency and social worker the possibility to distribute personal gift to participants such as scarf, accessory or chocolate box

Appendix 3: Informed Consent Form

Title of Research Project:	Women's health in humanitarian context: A qualitative study to explore factors affecting the utilization of family planning services among Syrian refugee women (aged 18-49) in Zaatari camp, Jordan

Researcher(s): Ruba Hikmat

	Please initial box
1. I confirm that I have read and have understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected.	☐
3. I understand that, under the UK's Data Protection Act, I can at any time ask for access to the information I provide, I can withdraw the data I provided up to two weeks after signing the consent form and, I can also request the destruction of that information if I wish.	☐
4. I understand that I will not be identified or identifiable in any report subsequently produced by the researcher	☐
5. I accept that taking part in an study intervention is voluntary and confirm that any risks associated with this have been explained to me	☐
6. I agree to take part in the above study.	☐
7. I agree that any my anonymity may be compromised if any illegal/reportable offences noted by the researcher	
8. I agree to having the interview/focus group digitally recorded	☐

Participant Name	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature
_____	_____	_____
Researcher	Date	Signature

The contact details of lead Researcher (Principal Investigator) are:

Ruba Hikmat

Mobile: 00962790580780

Email: rak39@bath.ac.uk

Appendix 4: Interview guide

The purpose of this study is to gain in depth information about family planning utilization among Syrian women (18-49) in Zaatari camp. Your feedback will help the government and humanitarian agencies and others in future to develop better family planning services so as to improve the quality of life of Syrian women. All information collected will be kept confidential. You can skip any questions during the interview and you can withdraw your participation before the start of the interview or in a week time after the completion of the data collection process.

Ice break questions for focus group discussion

- What is the ideal size of family in the camp? Back in Syria?
- How many children you have?

Proposed questions for the focus group discussion

Theme	General question

Knowledge and life skills and competencies	In your opinion, how women in the camp get to know about reproductive health services and how may they act to it?
Attitudes, values and beliefs	In your experience, what women in the camp think of reproductive health methods? what could woman do if they do not want to get pregnant? Have you proactively go out to look for reproductive health services? What was the situation back when you were in Syria? how you can compare the situation before with the situation now?
Competencies of professionals, professional standards, code of conduct, accountability mechanism	Can you give me example of what kind of obstacles women face when they approach reproductive health clinic? Was the services back in Syria better, how?
Services	Can you tell me the process of receiving family planning services, what good and bad in the whole process?
Decision making mechanism	Do you think women can decide when to get pregnant, can you explain to me how easy would it be for her to do so?
Social and cultural norms, practices, traditions and customs	What people in the camp say about the woman who avoid or delay their pregnancy? Or the women using family planning methods? Can you give me example of what they say?

Focus group discussion with Syrian women

Respondent characteristics participant ID

- Name (optional)
- Age of the respondents …….
- Marital status of the respondent (+years)
- Highest level of education attained by respondent
- Number of children (age, F/M per each)

Proposed questions for the key informant interview

Theme	General question
Knowledge and life skills and competencies	In your opinion, how women in the camp get to know about reproductive health services and how may they act to it?
Attitudes, values and beliefs	In your experience, what women in the camp think of reproductive health methods? what they do to delay pregnancy? When usually that happens? Have they proactively go out to look for reproductive health services? From your experience in the field and observation from the women, was the situation back in Syria better?
Policies, legislations and regulatory framework	Do you think the reproductive health policies and strategies in the country support the reproductive health intervention in the camp? Can you elaborate and explain to me how it may help?
Monitoring, Reporting and Oversight	How do you think the strategic planning helped increase the utilization of family planning services in the camp? What are the added value of having coordination and reporting mechanisms
Competencies of professionals, professional standards, code of conduct, accountability mechanism	In your experience what kind of obstacles women face when they approach reproductive health clinic? How the women in the camp compare the services in the camp vs back in Syria? You can you give us examples?
Services	Can you explain how women access services in the camp? what is bad and good in the process of obtaining services?
Decision making mechanism	Do you think women can decide when to get pregnant, can you explain to me how easy would it be for her to do so?
Social and cultural norms, practices, traditions and customs	What people in the camp say about the woman to avoid getting pregnant? Or the women using family planning methods? Can you give me example of what they say?

In-depth interviews with Community-Based Health/Social Workers

Respondent ID

- Tell me about your role and responsibilities as a health worker?

- How many years of experience do you have working with Syrian refugees?
- What brought you to work in Zaatari, and what motivated you to work in such a context?

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Appendix 5: Interview guide (Arabic)

الغرض من الدراسة التجريبية هو اختبار الادوات وتطويرها قبيل القيام في الدراسة الكاملة التي تهدف إلى فهم العوامل الي تسهم في استخدام اساليب تنظيم الاسره من قبل النساء السوريات (18-30) في مخيم الزعتري. ستستخدم وستدمج نتائج هذه الدراسة التجريبية مع الدراسة الكاملة لاستخدامها في عمليه صنع السياسات، بغيه تحسين تخطيط وتطويرخدمات الصحة الانجابية في المخيم. مع التنويه أنه سيتم التعامل مع المعلومات الشخصية بصوره سريه، وستكون جميع بيانات المدرجة في المنشورات والتقاريرمجهولة الهوية.

للمشترك الحرية الكاملة للإمتناع عن الاجابة عن أي من الاسئله المطروحة خلال المقابلة ، ويمكن للمشترك الانسحاب من المقابلة قبل البدأ في المقابلة أو في غضون أسبوع من عمليه إكمال جمع البيانات وذلك من خلال تبليغ مركز المرأة والفتاه في المخيم

اسئلة كسر الجليد

- ما هو الحجم المثالي للأسره في مخيم الزعتري؟ هل هو نفس العدد حينما كنتم في سوريا ؟
- كم عدد الأطفال لديك ؟ هل تريد المزيد من الأطفال؟

مجموعة المناقشة مع النساء السوريات

الاسئلة المقترحة

المعرفة والمهارات الحياتية والكفاءات	برأيك، كيف يمكن للمرأة في المخيم أن تعرف عن خدمات الصحة الإنجابية وماذا كان انطباعك عن توفر هذه الخدمات ؟
المواقف والقيم والمعتقدات	من تجربتك، ماذا هو رأي النساء في المخيم عن وسائل تنظيم الأسرة؟ ماذا يجب على للمرأة أن تفعل إذا لم ترغب في الحمل؟
	هل توجهت بنفسك للبحث عن خدمات الصحة الإنجابية؟ ماذا كان الوضع الخدمات المطبقة في ذلك الوقت ؟ كيف يمكنك المقارنة بين الوضع هنا والوضع عندما كنت في سوريا ؟
كفاءات المهنيين، والمعايير المهنية، ومدونة قواعد السلوك، وآلية المساءلة	هل يمكنك أن تعطيني بعض الامثلة عن أي نوع من العقبات أو التحديات التي تواجه النساء في المخيم عندما يحاولن زيارة إلى عيادة الصحة الإنجابية؟ هل كانت الخدمات في سوريا أفضل؛ وكيف؟

خدمات	هل يمكنك أن تصف لي عملية تلقي خدمات تنظيم الأسرة؟ ما هو جيد وما هوسيئ في العملية برمتها؟
آلية صنع القرار	هل تعتقد أن المرأة في المخيم تستطيع أن تقرر متى يمكنها الحمل أو تاجيل الحمل؟ هل يمكن أن تفسر لي كم هو سهل بالنسبة لهم للقيام بذلك؟
الأعراف والممارسات الثقافية والاجتماعية والتقاليد والعادات	ماذا يقول المجتمع في المخيم عن النساء اللواتي يتجنبن أو يؤخرن حملهن، أو النساء اللواتي يستخدمن وسائل تنظيم ألسرة؟ هل يمكنك أن تعطيني بعض الأمثلة على ما يقولونه؟

خصائص المشارك المشارك

- الاسم: (اختياري)
- عمر المشتركة
- الحالة الاجتماعية (+ سنوات)
- المستوى التعليمي الذي حققته المشتركه
- عدد الأطفال (عمركل طفل والجنس)

مقابلات معمقة مع الصحة المجتمعية / الاخصائيين الاجتماعيين

أسئلة مقترحة لمقابلات المعلوملتية مع الخبراء

المعرفة والمهارات الحياتية والكفاءات	برأيك، كيف يمكن للمرأة في المخيم أن تعرف عن خدمات الصحة الإنجابية وكيف كان الانطباع الأولي لهن؟
المواقف والقيم والمعتقدات	من خبرتك، ما هو انطباع النساء في المخيم عن وسائل تنظيم الأسرة؟ ما هو الوسائل والطرق التي تستخدمها النساء لتأخير الحمل؟ تحت أي ظروف وكيف يحدث ذلك؟
	هل يخرجون بشكل استباقي للبحث عن خدمات الصحة الإنجابية؟ من واقع تجربتك في الميدان والتغذية الراجعة من النساء في المخيم، هل كان الوضع في سوريا أفضل؟ وكيف

السياسات والتشريعات والإطار التنظيمي	هل تعتقد أن سياسات واستراتيجيات الصحة الإنجابية في البلاد تدعم برامج الصحة الإنجابية في المخيم؟ هل يمكنك تفصيل وشرح لي كيف يمكنها أن تساعد؟
الرصد والإبلاغ والرقابة	هل تعتقد أن التخطيط الاستراتيجي ساعد على زيادة الاستفادة من خدمات تنظيم الأسرة في المخيم، وإذا كان الأمر كذلك كيف؟ ما هي قيمة أو فائدة وجود آليات التنسيق والإبلاغ داخل المخيم؟
كفاءات المهنيين، والمعايير المهنية، ومدونة قواعد السلوك، وآلية المساءلة	في تجربتك أي نوع من العقبات التي تواجهها النساء عندما تزور عيادة الصحة الإنجابية؟ كيف تقارن النساء في المخيم الخدمات التي يحصلون عليها في المخيم والخدمات التي كان يحصلون عليها في سوريا؟ هل يمكنك أن تعطينا أمثلة؟
خدمات	هل يمكنك أن تصف كيف يمكن للنساء الوصول إلى الخدمات في المخيم؟ ما هو السيء والجيد في عملية الحصول على الخدمات الصحة الانجابية؟
آلية صنع القرار	هل تعتقد أن المرأة في المخيم تستطيع أن تقرر متى تكون حاملا، هل يمكنك أن تشرح لي كيف سيكون من السهل عليها أن تفعل ذلك؟
الأعراف والممارسات الثقافية والاجتماعية والتقاليد والعادات	ماذا يقول المجتمع في المخيم عن المرأة تتجنبن الحمل؟ أو النساء اللاتي يستخدمن وسائل تنظيم الأسرة؟ هل يمكنك أن تعطيني مثالا على ما يقولونه؟

معلومات عن المشترك

- أخبرني عن دورك ومسؤولياتك في القطاع الصحي؟
- عدد سنين الخبرة في العمل مع اللاجئين السوريين؟

- ما الذي دفعك للعمل في الزعتري، وما الذي دفعك للعمل في مثل هذا السياق؟

كتيب توضيحي للمشاركين حول الدراسة

جامعة باث، المملكة المتحدة

صحة المرأة في الأزمات: دراسة نوعية للبحث في العوامل التي تؤثر على استخدام خدمات تنظيم الأسرة بين اللاجئات السوريات (18-49 سنة) في مخيم الزعتري، الأردن

مقدمة

مرحبا، انا إسمي (ربى حكمت). أنا أجري بحثا دراسيا حول صحة المرأة في الازمات مع التركيز على تنظيم الاسرة في مخيم الزعتري. استكمال دراسة بحثية هو شرط اساسي ومتطلب في برنامج دكتوراه في الصحة في جامعة باث والتي أنا جزء منها. لاستكمال البحث، أريد أن أتحدث معكم عن آراء الناس وسلوكهم داخل المخيم فيما يتعلق بالعوامل المؤثرة على استخدام خدمات الصحة الانجابية وبالاخص، تنظيم الأسرة. مع التنويه أن المشاركة في هذا البحث هي طوعية، لا توجد أي دفوعات أو فوائد فورية متاحة للمشارك. المعلومات التي ستقدمها المشتركة ستستخدم لمساعدة الحكومة والوكالات الإنسانية على تحسين خدماتها الصحية في المخيم، والتي من شأنها تحسين رفاه للاجئات السوريات.

سيتم أجراء مقابلات مع مجموعات مختلفة من النساء في مخيم الزعتري وبعض العاملين الصحيين حول نفس موضوع ولكن بشكل منفصل.ستبقى جميع المعلومات التي سنحصل عليها مجهولة الهوية تماما، ولن يتم الاحتفاظ بسجلات هويتك فيما يتعلق بالردود الخاصة بك، ما لم تبلغنا مسبقا.

ستستغرق المقابلة 45 دقيقة. إذا كنت توافق على المشاركة، يرجى العلم أن لديك الحق الكامل في طلب مزيد من التوضيح في أي خطوة خلال المقابلة، ولديك الحق في عدم الإجابة على أي سؤال إذا كنت لا تريد ولديك الحق كذلك الانسحاب قبل المقابلة أو بعد الانتهاء من المقابلة.

هل لديك اسئلة؟

هل أنت على استعداد للمشاركة في هذا البحث؟ نعم / لا (نهاية المقابلة)

.....

غرض الدراسة

المباعدة بين الولادات وتحديد حجم الأسرة حق لا يسهم فحسب في تعزيز صحة المرأة ورفاهها، بل إنه يحسن أيضا التنمية الاقتصادية للأسر والمجتمعات المحلية. في الأردن، يتفاوت مستوى الاستفادة من خدمات تنظيم الأسرة، فهو متوسط بين النساء الأردنيات والنساء السوريات اللائي يعشن في المناطق الحضرية. لكن النسبة بين النساء السوريات اللاتي يعشن داخل مخيم الزعتري منخفضة جدا.

تهدف هذه الدراسة إلى استخلاص رأيك من ضوء تجربتك، والتي سيترجم لاحقا إلى توصيات موجهة إلى الحكومة والأمم المتحدة للنظر فيها خلال رسم المداخلات لتحسين نوعية خدمات الصحة الإنجابية وإمكانية الوصول إليها.

سيتم تطوير الدراسة باللغة الإنجليزية وسيتم نشرها على الإنترنت.

لماذا تم اختيارك للمشاركة في الدراسة؟

العاملون الصحيون: لقد تم اختيارك للمشاركة في البحث مع آخرين بسبب خبرتك الطويلة في برامج الصحة الإنجابية في مخيم الزعتري.

النساء السوريات: تم اختيارك عشوائيا بالتشاور مع الأخصائية الاجتماعية في المخيم والعاملين في مركز المرأة و الفتاة.

هل يجب علي المشاركة؟

لك الحرية في أن تقرر المشاركة في هذا البحث أم لا

ماذا سيحدث إذا شاركت؟

سوف يتم طلب موافقتك الخطية قبل المقابلة بعد أن تفهم تماما التفاصيل، الالية، هدف الدراسة و أماكن استخدام ونشر المعلومات. سوف يطلب منك الايجابة على قائمة من الأسئلة من خلال مقابلات معرفية أو مناقشات مجموعة التركيز. وسيتم تسجيل المقابلات باستخدام مسجل صوتي وتوثيقها باللغة العربية وترجمتها لاحقا إلى اللغة الإنجليزية. البيانات التي سيتم جمعها ومن ثم سيتم تحليلها بطريقة علمية ممنهجة

المصروفات و / أو المدفوعات:

لن يتم إعطاء أي حافز أو تعويض عن وقتك للمشاركة. والنفقات الوحيدة التي سوف تكبدها هو وقتك.

هل هناك أي مخاطر في المشاركة؟

سيتم تطوير نتائج البحث بناءا على وجهات نظر المشاركين وآرائهم وخبراتهم في مجال خدمات الصحة الإنجابية. وسوف يقوم الباحث بتطبيق المبادئ الأخلاقية خلال المقابلة وطوال فترة إعداد التقرير النهائي لضمان عدم الكشف عن هوية جميع المشاركين.

هل هناك أي فوائد في المشاركة؟

ليس هناك فائدة مباشرة أو غير مباشرة للمشاركة.

ماذا لو كنت غير راض أو إذا كان هناك مشكلة؟

إذا كنت غير راض أثناء الدراسة، أو إذا كنت تواجه أي مشكلة فلا تتردد في إعلامنا عن طريق الاتصال ب [ربى حكمت، R.H.S.Kawafha@bath.ac.uk] ونحن سوف نكون سعداء للمساعدة. إذا كنت لا تزال غير راض أو لديك شكوى تريد أن يكون بها طرف اخر يجب عليك الاتصال المشرف البحوث في جامعة باث +44 (0) 1225 38 5477.

هل ستبقى مشاركتي سرية؟

ستبقى مشاركتك سرية والمعلومات مجهولة الهوية. سيتم نسخ البيانات وحفظها أيضا خلال مرحلة التحليل في مكان امن ومقفل تحت مع الباحث ولن يتم مشاركتها مع أي شخص باستثناء فريق البحث في الجامعة.

ماذا سيحدث لنتائج الدراسة؟

ستقدم نتائج الدراسة إلى جامعة باث للموافقة عليها، بمجرد الموافقة عليها، سيتم مشاركتها مع صندوق الامم المتحدة للسكان ومع الحكومة الأردنية ممثلة بوزارة الصحة.

ماذا سيحدث إذا أردت التوقف عن المشاركة؟

لديك الحق في الانسحاب من الدراسة دون تقديم أي تفسير، إما قبل البدء في المقابلة أو خلال أسبوع بعد الانتهاء من جمع البيانات وذلك عن طريق ابلاغ ضابط الارتباط او العاملين في مركز المرأه و الفتاه

شكرا جزيلا على أخذ الوقت لقراءة كتيب المعلومات هذا.

إذا كان هناك أي شيء كنت لا تفهم أو إذا كنت ترغب في مزيد من المعلومات، يرجى الاتصال: ربا حكمت (الباحث الرئيسي)

Appendix 6: Informed consent form (Arabic)

استمارة الموافقة المسبقة

عنوان مشروع البحث	صحة المرأة في الأزمات: دراسة نوعية للبحث في العوامل التي تؤثر على استخدام خدمات تنظيم الأسرة بين السيدات السوريات (18-49 سنة) في مخيم الزعتري، الأردن

إسم الباحث ربى حكمت

أؤكد أنني قرأت وفهمت ورقة المعلومات الخاصة بالدراسة أعلاه. حيث أتيحت لي الفرصة للنظر في المعلومات وطرح الأسئلة، وتم الأجابة على التساؤلات بشكل مرض	☐
إنني أدرك أن مشاركتي طوعية وأن لي الحرية في الانسحاب قبل البدء في المقابلة بدون إبداء أي سبب، ولي حرية الإمتناع عن اجابة اي سؤال دون أن تتأثر حقوقي	☐
وأنا أفهم أنه بموجب قانون حماية البيانات ، أن الباحث سيتم التخلص من جميع البيانات الأولية ولكن يمكنني الطلب مسبقا الحصول على المعلومات الأولية التي قدمها خلال المقابلة إذا رغبت في ذلك	☐
وأنا أفهم أن معلوماتي الشخصية لن يتم التعرف عليها أو تحديدها في أي من التقرير التي ستصدر لاحقا من قبل الباحث	☐
إنني أوافق على المشاركة طوعيا في الدراسة مع التأكيد أنه تم شرح لي المخاطر المرتبطة بالمشاركة في البحث	☐
أوافق على المشاركة في الدراسة المذكورة أعلاه	☐
أوافق على المشاركة في مجموعة المقابلات وتسجيل المقابلة صوتيا للتوثيق	☐

إسم المشترك في الدراسة التاريخ التوقيع

إسم الميسر الذي اخذ الموافقة التاريخ التوقيع

تفاصيل الاتصال مع الباحث الرئيسي هو:

ربى حكمت، موبيل: [redacted]

البريد الإلكتروني: R.H.S.Kawafha@bath.ac.uk